Patient Registration

Please Print

Patient Name_____
Last First Middle

Address_____City_____Zip_____

Home Phone_____Work_____Ext_____Cell_____

Birthdate_____-_____-_____Social Security #_____-_____-_____ Gender_____Marital Status_____

Employer_____

Referred by_____Emergency Contact_____Phone_____

If the patient is a child, please give additional information:
Mother/Guardian's Name_____Father/Guardian's Name_____

Are biological parents_____Married_____Separated_____Divorced_____Other

Who has legal custody of the child?_____

Child lives with_____Relationship_____
Child is carried on the insurance of (Please check all that apply):
__Biological Mother_____Biological Father_____Step Mother_____Step Father_____Grandparent_____Adoptive Parent___Other

Do You Have Insurance Coverage? _____Yes _____No
Primary Insurance Information:

Insurance Company Name_____Phone_____

Subscriber_____Subscriber's Birthdate_____

Address if different than above_____City/State/Zip_____

Member ID #_____Group #_____Effective Date_____

Relationship_____Subscriber SS #_____

Subscriber's Employer_____

Secondary Insurance Information:

Insurance Company Name_____Phone_____

Subscriber_____Subscriber's Birthdate_____

Member ID #_____Group #_____Effective Date_____

Do you or your partner have any other insurance coverage_____Yes_____No

The above information is correct and all insurance information is listed.

Date_____***Signed***_____

Medical Profile

Have you been treated by any other Mental Health Providers in the last 12 months___No__Yes

If yes, where_____

Medical Doctor_____Last Exam_____

Current Medical Conditions (check all that apply):

__Allergies	__Frequent	__Vision Problems
__Asthma	__Frequent Headaches	__Smoker
__Arthiritis	__Hay Fever	__Other
__Back Pain	__Heart Problems	_____
__High Blood Pressure	__Infectious Disease	_____
__Cancer	__Irritable Bowels	_____
__Chronic Pain	__Stomach Problems	
__Diabetes	__Skin Problems	

Please list all current medication you are taking:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Do you have any medication allergies? ___No ____Yes:_____

Past Surgery_____

How do you rate your current physical health? ___Excellent ___Good ___Fair ___Poor

Number of caffeinated beverages per day_____

Patient Signature_____

Date_____

Psychiatric Consultants & Therapists, S.C.

Coordinating you care with your Primary Care Physician offers you the most comprehensive treatment. This is an opportunity for your medical and mental health professionals to discuss how any medical conditions you may have could affect your mental health issues, or how any mental health issues could affect any medical conditions you may be experiencing. While we always encourage coordination of care with your medical doctors, you must first sign a consent to allow us to release this information:

Please check one of the following and sign below:

__I do not have a primary care physician

__I refuse to give permission for my therapist or doctor to either correspond by letter or discuss over the telephone any information about my mental health issues.

__I give permission for Psychiatric Consultants and Therapists, S.C., and my primary care physician or other designated health care provider to exchange information regarding coordination of my medical and mental health issues.

If you are consenting to coordination of care between your therapist or psychiatrist and you medical doctor, please list the contact information for your medical doctor:

Name of Doctor_____

Address_____

City/State_____

Zip Code_____

Phone Number_____

Name (print):_____

Signature:_____

Date_____

AUTHORIZATION TO RELEASE INFORMATION
ASSIGNMENT OF INSURANCE BENEFITS
PATIENT RIGHTS AND RESPONSIBLITIES
INFORMED CONSENT

Release of Information:

I hereby authorize Psychiatric Consultants & Therapists, S.C. to release to my insurance company and/or associated professionals any information from my medical record, which may be necessary to determine benefits payable under my policy and/or expedite treatment.

Assignment of Benefits:

I authorize payment directly to Psychiatric Consultants & Therapists, S.C. I understood I will be charged for missed appointments at the regular rate not cancelled at least 24 hours prior to appointment time.

I have been informed of the cost of treatment and I have received a copy of the fee schedule.

I understand that I am responsible for all balances to be paid within 90 days of the date of service regardless of the status of the insurance claims. We also expect regular payment on all past due accounts. All co-payments are due at time of service.

Informed Consent:

I have been informed of my rights as they related to all phases of treatment. I will agree to sign a treatment plan after my first session that explains my diagnosis, types of treatment, goals for treatment, and consequences of not receiving proper services.

I have been informed and have read my patients rights and responsibilities and have been given a copy of "Your rights and Grievance Procedures". I am consenting to treatment.

The time period of which this consent is effective is no longer than 15 months from the time consent is given. I have the right to withdraw the informed consent at any time in writing.

Date_____ **Signature:** _____
(Patient or Guardian)

Witness: _____if not completed at PCT

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

By signing this form, I_____ acknowledge that Psychiatric Consultants & Therapists, S.C. has provided me with a copy the Privacy Notice that explains how my health information will be handled in various situations. I understand that I am able to discuss any questions I may have regarding the privacy notice with my provider, and I am aware that a Federal law requires that a signed copy of this form be retained in my file.

Signature_____

Date_____

Psychiatric Consultants and Therapists, SC

We appreciate your selecting us as your treatment providers. The following will help you understand the financial relationship between you as the patient and Psychiatric Consultants and Therapists (PCT) as your treatment provider. If you have any questions about your financial commitment to PCT, please contact Mary Jo Caminiti at 414-224-3737 ext 222.

Patient Responsibility:

Understanding insurance coverage, especially authorization for services, can be complex. While PCT makes every attempt to gain authorization for services, it is ultimately the patient's responsibility to call their insurance prior to seeking services to understand both their benefits for behavioral health care and to obtain authorization for services. Any claims submitted to your insurance on your behalf that may not be covered for any reason will remain your responsibility.

Registration:

We will ask all patients to register at their initial appointment and once a year thereafter. However, if you move or change insurances, we ask that you update us with new information. It is your responsibility to communicate any changes in coverage so we may bill your insurance. Not all of our doctors, nurses or therapists are in every insurance network so it is your responsibility to know your behavioral health benefit coverage since coverage varies significantly if you see an out of network provider. In addition, providers may work for other clinics. **Do not assume that if your provider is in network with another clinic that they will be in network with PCT**.

Deductibles and Co-Payments:

The deductible is the amount that is your responsibility before your insurance pays. While we will call on your benefits, it is your responsibility to know how much your deductible is. We will ask for you to pay the cost of the session at the time of service since the deductible is your responsibility.

Co-payment is the money that is your responsibility according to your insurance benefits. Co-payments must be paid at the time of service. Your provider may choose not to see you if you are unable to pay your co-payment.

Patients will not be billed for co-payments or deductible. These must be paid at the time of service.

Billing Insurance:

We bill insurance as a courtesy to you. In addition to paying your co-pay at the time of service or paying your deductible, you may have a co-insurance. We allow 30 days for your insurance to pay the claim. After that time we will require payment from you. Be an proactive consumer and call your insurance company to find out why your claim has not been paid.

Patients without Insurance:

If you are without insurance, have a high deductible or have exceeded your benefits, PCT wants to work with you. Talk with your provider about a self pay discount or hardship discount. **All services with these discounts must be paid for at the time of service**.

Collections:

Accounts are to be paid upon receipt of the first statement. The first statement reflects what insurance has paid and your co-insurance. Any amount outstanding is your responsibility and must be paid when you receive your first statement. You can pay with cash, check or any major credit card. We are willing to work with you regarding payment plans to avoid your account from being delinquent. If you do not pay when you come to your appointment or when our billing office makes an attempt to contact you, your account will be discussed with your doctor or therapist and may be turned over to a collection agency which will prevent you from being seen at PCT or getting your medication refilled. **Please note that you may be discharged from care if you fail to make any attempt to pay your bill.** This includes providers that you are no longer seeing at PCT.

Office policy states that care cannot be continued at this facility after services are included in a **bankruptcy** case. If filing bankruptcy is necessary and you must include PCT in your bankruptcy, our intake specialist, your doctor or therapist can give you a list of resources outside of our clinic for services.

Fees:

We believe our fees are reasonable. You are responsible for any outstanding payment regardless of an insurance company's payment to us. Any disagreement about what your insurance company pays is between you and them and should be directed to them since we have no authority to act on your behalf. In addition, we reserve the right to bill for services not covered by insurance such as telephone calls, form completion, copying of medical records and overuse of the answering service.

Insufficient Funds:

If your check is returned for insufficient funds, you will be required to pay our current bank rate fee and any other charges associated with this.

Missed Appointments:

If you miss an appointment or don't cancel before 24 hours, you may be charged for the missed appointment. In addition, if this is with your doctor, it may affect the refills of your prescriptions. Patients that miss more than two appointments may be discharged from the clinic.

I have read the financial policy for Psychiatric Consultants and Therapists and I understand the policy and will abide by it.

_____Date_____

Patient Signature

Psychiatric Consultants and Therapists Medication Policy

If medication is part of your treatment at this clinic, please understand that obtaining medication refills can be a complex process as we try and communicate with pharmacies and insurance companies to help you get your prescription.

*__At each appointment, your doctor will give you a written prescription with enough refills to last until your next appointment__. You will be asked to come back within that time period to discuss how your medication is working and to get your next written prescription.

*Please take your written prescription to your pharmacy so they have a record of the number of refills allowed. **Do not have your pharmacy contact us if you still have refills from your prescription.**

*__Do not wait until you run out of medication refills to schedule your next appointment__. Please schedule your next appointment immediately after each visit. It is best to have two weeks of medication left when you come in.

*If your appointment is canceled or rescheduled for any reason, you may need to request a refill by telephone. Do not wait until you run out of medication to call us. **Telephone requests will require three business days to be processed.** Your doctor may not be available every day and sometimes medication will need a prior authorization which will take additional time. Also, if you use a mail order company, please make sure your appointment is 14 days or more before your medication runs out. **No routine refill requests will be processed by our staff after regular business hours or after noon on Fridays or on weekends**. If you call with an emergency medication request on weekends, you will only be given a 3-4 day supply.

*You will be allowed one telephone or fax refill as a courtesy if you cancel an appointment. However, future prescriptions written at times other than appointments may result in a charge to you or a limited supply of medication (e.g.10-20 pills) to get you through until your next scheduled appointment. **You will be responsible for any additional costs such as co-payments if you allow yourself to run out of medication before your next scheduled appointment and need to have your medication refilled before your next scheduled appointment.**

*According to federal law, certain medications such as stimulants can only be obtained with a written prescription for no more than a month supply. **Effective immediately, these prescriptions will only be written during appointments and will not be mailed to patients.** At your appointment you may be given follow-up prescriptions that need to be filled within a specific time period. It is the patient's responsibility to take these prescriptions to a pharmacy within the valid time period.

There are many complex issues involving the refill of medications. Keeping your appointments, taking your prescriptions to the pharmacy and making follow up appointments before your medication runs out, will enable us to give you the quality care that you need without wasting unnecessary time with medication refills. Please communicate to your doctor if you have any questions regarding the procedures for refilling medications.

I have read the above policies on medication refills and agree to abide by them during my treatment at Psychiatric Consultants and Therapists. I also understand the importance of taking my medications exactly as my doctor has instructed and I will communicate any concerns I have.

Patient:_____Date:_____

AGREEMENTS AND DISCLOSURES

(for all patients over 18 years of age)

Please read the following carefully. Each item MUST be marked either "yes" or "no." If you have any questions, please ask the receptionist, doctor or therapist.

AGREEMENTS

1. I authorize Psychiatric Consultants and Therapists, SC to contact the referral source for professional and treatment purposes, understanding that personal information will need to be released to my insurance company or the company that manages my benefits.
   _____Yes _____No

2. I authorize Psychiatric Consultants and Therapists, SC to bill my insurance/managed care company for the psychotherapy and medication management. Psychiatric Consultants and Therapists, SC may need to disclose clinical information necessary to process all claims.
   _____Yes _____No

3. I authorize my insurance company to make payment directly to Psychiatric Consultants and Therapists, SC. I understand that I am responsible for knowing my benefits and paying any claims that are not covered by insurance.
   _____Yes _____No

4. I authorize Psychiatric Consultants and Therapists, SC to mail any correspondence regarding my treatment, satisfaction with treatment, updates about my treatment and educational programs during and after the completion of my treatment to my home mailing address.
   _____Yes _____No

5. I understand that my treating clinician may release information about my situation ONLY for treatment, payment, or health care operations.
   _____Yes _____No

6. I want my primary care physician to be notified of my treatment at Psychiatric Consultants and Therapists, SC. Coordination of care between providers can be helpful when providing care.
   _____Yes _____No

   Name of Primary Care Doctor _____
   Address _____
   City _____
   Phone Number _____

7. I authorize my therapist or doctor's office to leave reminder calls or other information at home or on my cell phone. Please list numbers that we can leave information on _____
   _____NO, my therapist or doctor's office cannot leave any information on a designated answering machine or voice mail.

DISCLOSURES

I understand that Psychiatric Consultants and Therapists, SC cannot be held responsible for being unable to access me due to telephone devices that may block their calls, my use of a pager system in which I cannot directly be reached, any form of caller identification, or any type of device that does not allow my therapist or doctor to make direct telephone contact with me.

_____Yes _____No

SIGNATURE_____DATE:_____

PRINTED NAME_____