The Healthy Mind PSYCHIATRIC SERVICES

900 Straits Tpk Suite D Middlebury, CT 06762

New Patient Registration:

Patient's First Name_____ Last Name _____

Patient's Telephone: Home_____ Cell _____

Email: _____

Patient's Date of Birth: _____ Gender____M____F

Patient's Address: _____

City _____ Zip Code _____

<u>Primary Insurance:</u>

Insurance Co. Name: _____ Employer: _____

ID# _____ Group# _____

Name of Insured _____ Date of Birth_____

<u>Secondary Insurance:</u>

Insurance Co. Name: _____ Employer: _____

ID# _____ Group# _____

Name of Insured _____ Date of Birth_____

I authorize the release of medical or any other information necessary to process this claim. I request that payment of authorized benefits be made to <u>The healthy Mind Psychiatric Services.</u>

Signature: _____ Date: _____

Current Psychiatric Symptoms:

- ○ **Low or Sad mood**
- ○ **Difficulty Concentrating**
- ○ **Increased anxiety**
- ○ **Difficulty with energy**
- ○ **Feelings of loss or guilt**
- ○ **Suicidal thoughts**
- ○ **Feeling other people are there to harm you**
- ○ **Panic symptoms**
- ○ **Difficulty sleeping**
- ○ **Frequent headaches, body aches and pains**
- ○ **Excessive sleep**
- ○ **Decreased interest in pleasurable activities**
- ○ **Hearing voices**
- ○ **Having strange visual experiences**
- ○ **Nightmares**
- ○ **Irritability**
- ○ **Mood swings**
- ○ **Others**

Allergies:

Medical issues:

Surgical History:

List if any previous psychiatric

Hospitalization:

Primary care Provider, Specialist, or Therapist:

Who referred you? Or how did you hear about us?

CURRENT MEDICATIONS, including

Herbal remedies and over the counter

Medications:

1.
2.

3.

4.

SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS,

FINANCIAL AGREEMENT

Patient Name: _____ Date of Birth: _____

I understand that it is my responsibility to check with my insurance company to verify what my policy may or may not cover.

I accept full financial responsibility for any charges incurred today if:

1. **The services rendered or supplies used / purchased are not covered under my insurance plan;**
2. **My insurance plan requires that I pay a deductible, co-payment, or co-insurance;**
3. **There are charges that have resulted because I have failed to provide current and valid insurance policy information; or**
4. **My insurance plan requires that I obtain a referral prior to my visit and I do not have on in place.**

I agree:

1. **Payment must be made to The Healthy Mind Psychiatric Services, by my insurance carrier for services rendered or prescription received.**
2. **The Healthy Mind may use and disclose medical information about me for services and procedures; so they may be billed and collected from insurance agency or any other third party.**
3. **To pay for my copay and other charges that are not covered by my insurance carrier today or make financial agreements satisfactory to the Healthy Mind for payment.**
4. **If I am not able to pay The Healthy Mind Psychiatric Services for balances within the 30 days, I will have to pay a 1% interest charge, compounded, per month for my balance.**
5. **To pay for any returned checks, fees incurred by The Healthy Mind Psychiatric Services.**
6. **If I am the Parent / Guardian bringing in a child for treatment, that I am responsible for all fees incurred by the child.**
7. **To pay collection expenses and attorney's fees if my account is sent to the collection agency or an attorney for collection.**
8. **To pay a fee of $ 30, if I fail to provide a 24 hour advance notice to cancel my appointment.**

Patient's Signature: _____ Today's Date _____

THE HEALTHY MIND PSYCHIATRIC SERVICES

It is your responsibility to keep all written prescriptions safe.

Controlled substance prescriptions will not be replaced without a policy report of theft.

These medications will not be refilled on Friday, weekends, or holidays. It is your responsibility to keep all appointment and to keep track of medications quantity and refill due dates.

Patients Treatment Agreement

1. **I agree that the medication I receive is my responsibility and I agree to keep it in a safe, secure place. I agree that lost medication will not be replaced regardless of why it was lost.**
2. **I agree to take my medications as my doctor has instructed and not to alter my medication without first consulting my doctor.**
3. **I agree NOT to obtain medications from any doctor or other sources without telling my treating doctor.**
4. **I understand that a missed appointment will result in me not being able to get my medications until the next scheduled visit.**
5. **I understand that any violation of this agreement will result in termination of treatment and I will be discharged from all services.**
6. **I agree and authorize the staff of The Health Mind Psychiatric Services to leave a voicemail message confirming/changing/rescheduling appointment at**

_____ or _____

Date _____ **Client's Signature _____**

Witness Signature_____

Collection of Deductible/Co-Insurance Form

Patient Name: _____ Date of Birth:_____

Patient's ID # & Health Plan: _____

Patient's Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Dear Patient:

We will verify with you insurance carrier whether or not your insurance coverage indicates a deductible balance. You are responsible for paying for services that call under your deductible/co-insurance.

As a participating provider, my physician or healthcare practitioner will submit the claim on my behalf for services rendered, directly to my insurance carrier. Upon reception of my Explanation of Benefits from my insurance carrier, I understand that I am responsible for any applicable deductible coinsurance and **I must payment directly to my provider within the 30 days.** I have agreed to pay for any applicable deductible/co-insurance. If I do not pay in 30 days, I understand that my provider may seed alternative methods to collect the payment.

I understand that I am responsible for paying my provider directly for any applicable deductible/co-insurance/co-payment; this is mandatory requirement when receiving healthcare services. I understand that if I do not fulfill this requirement, my provider may notify my insurance carrier, and seed alternative methods of collection, Failure to meet my obligations is a violation of my agreement with my insurance carrier and the carrier may take additional action. I also understand that if I have longstanding unpaid deductibles/co-insurance/co-payments owed to my provider, my provider may terminate the doctor/patient relationship as a result, subject to the requirements for state and/or federal law.

Patient/Guardian Signature_____ Date_____

The Healthy Mind Psychiatric Services

900 Straits Tumpike Suite D, Middlebury, CT 06762

133 Scovill Street, Suite 102, Waterbury, CT 06705

ATTENTION ALL PATIENTS

CANCELLATION POLICY

A **NO-SHOW** FEE OF $30 WILL BE BILLED TO YOU IF YOU **DO NOT** GIVE AT LEAST 24 HOUR NOTICE PRIOR TO CANCELLATION OF YOUR APPOINTMENT. ALSO KEEP IN MIND THAT 3 CONSECUTIE CANCELLATIONS WILL BE CONSIDERED AS NONCOMPLIANCE/NO SHOW AND 2 NO SHOWS WILL BE GROUND FOR TERMINATION OF TREATMENT.

REFILL POLICY

WE **DO NOT** CALL ANY PRESCRIPTION REFILLS AS IT TAKES A LOT OF STAFF TIME. PLEASE CHECK ALL YOUR MEDICATIONS BEFORE COMING FOR YOUR VISIT AND GET YOUR PRESCRIPTION AT TIME OF YOUR VISIT.

OFFICE VISIST POLICY

All patients will be required to present a valid driver's license or photo ID, their current medical insurance card and co-pay at every office visit.

Patients without verifiable health insurance will be required to demonstrate a form of payment before being seen.

Signature of Patient's or Provider's: _____

Date: _____