PsychBC

PATIENT INFORMATION FORM

☐ **ID Verified ____**
(Staff Use Only)

Patient Name _____Date _____☐ Male ☐Female

Address_____DOB ____/____/_____ Age ____
(Street)

_____ _____ _____SSN _____
(City) (State) (ZIP Code)

Phone _____ _____ _____
(Home) (Cell) (Work)

*Please note * which is your preferred phone number.*

Marital Status _____ Student? ☐ Yes ☐ No

Parent or Guardian _____Phone _____
(If Applicable) (Preferred Phone Number)

Emergency Contact _____ _____ Relation to Patient_____
Name Phone Number

Insurance Company _____ Phone _____

Mental Health Carrier_____Phone_____
(If Different from Primary Insurance Carrier)

Name of Policy Holder_____Policy Holder DOB ____/____/_____

SSN of Policy Holder_____ Relation to Patient_____

Name/address of your primary care physician _____

Pharmacy Name _____ Phone _____

PROFESSIONAL SERVICES AGREEMENT

I understand that the effectiveness of mental health services depends on efforts of the patient as well as those of the practitioner (Clinician) and I promise to make my best effort to comply with these procedures. These best efforts will include open and honest discussion of my thoughts and feelings, as well as an effort to perform any exercises or homework assignments that may be recommended. I also agree to return, undamaged, any materials that have been loaned to me as part of the procedures and understand that I am liable for the cost of these materials. I understand that the effectiveness of the procedures cannot be guaranteed and that the Clinician has sole professional responsibility for all services provided.

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 Clinician at least two weeks in advance so that effective planning for continued care can be implemented. I also agree to notify the Clinician **at least 24 business hours in advance** if I will be unable to attend any session. I understand that if I fail to make such notification, I may be charged for the full cost of the session, which will not be reimbursable by my insurance company. I agree to be responsible for these charges.

I understand that conversations with the Clinician will be of a confidential nature. I authorize my Clinician to discuss my treatment with other treatment providers to coordinate my care. I further understand that the Clinician, by law, must report actual or suspected child or elder abuse to the appropriate authorities. In addition, the Clinician has a legal responsibility to protect anyone that the patient 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 Clinician will make reasonable efforts to resolve these situations before breaking confidentiality. I also understand that in order to ensure patient confidentiality and privacy, electronic recording is strictly prohibited within any PsychBC office.

(please see reverse side)

I understand that prescribed medication can only be provided in coordination with regular office visits, in order to provide me with safe and appropriate medical care, and that any urgent requests by me for medication refills without an office visit will incur a $25 administrative fee, non-reimbursable by insurance.

My signature below indicates that I have agreed to these terms and have read and understand a "Notice of Privacy Practices" and a "Welcome to our Practice" informational flyer describing my rights and responsibilities as a patient or guardian.

X_____ _____

(Signature of Patient or Guardian) (Date)

FINANCIAL AGREEMENT

Patients are responsible for providing accurate information about their insurance benefits. Failure to complete this section or inaccurate information will make patients fully responsible for all charges. Patients are responsible for notifying PsychBC of any changes in insurance within 30 days; otherwise, you will be responsible for payment in full. In most cases, patients are responsible for making the initial phone call to their insurance companies. This form will be kept on file for one year from date of signature; patients must complete this form on an annual basis.

I request that PsychBC, as the agent for the Clinician, submit bills to the insurance company that I have listed on the reverse side of this form, and I grant permission to the Clinician and PsychBC to release such confidential information as is necessary to obtain payment from the insurance company. In the event that my insurance company fails to observe Ohio prompt pay standards or otherwise fails to adhere to relevant rules and standards, I grant permission to PsychBC to share information related to my insurance claim with the Ohio Department of Insurance.

I understand that I am financially responsible for the cost of the mental health services provided to me (my child) and for any portion of the fees not reimbursed or covered by my health insurance. I understand that my copay is due at time of service, otherwise a $10 billing fee may be charged each time for any bill that is sent if I have an outstanding patient balance . If my mental health care is provided under the terms and conditions of a managed mental health care program to which the Clinician is contracted, my financial responsibilities may be limited by the terms of that contract. I understand that my failure to pay these bills may result in collection procedures (including court proceedings) being taken against me by the Clinician or a collection agency contracted by the Clinician to collect these bills. I also understand that if my account is placed in collection procedures, neither I nor any other patient of PsychBC for whom I am the guarantor will be able to schedule appointments with any other PsychBC clinician.

I understand that PsychBC contracts with more than 50 insurance carriers/managed care companies. I will contact my insurance company directly if I wish to know the specific contract rate my carrier has with PsychBC.

I authorize the release of any medical information necessary to process my claim.

My signature below indicates that I have agreed to the above terms.

X_____ _____

(Signature of Patient or Guardian) (Date)

FINANCIAL RESPONSIBILITY *(if other than patient)*

Name _____ □ Male □ Female DOB ____/____/_____

Address_____ SSN _____

(If Different from Patient)

_____Phone_____

Signature of Financially Responsible Party _____ Date _____

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