Patient Registration

PATIENTS NAME (Last, First, M. Initial):		
DATE OF BIRTH	Social Security number	
SEX	MARITAL STATUS: □ Single □ Married □ Divorce □ Separated □ Other	
□ Female □ Male	Spouse's Name:	Phone No:
ADDRESS	APT. NO.	CITY
STATE ZIP	HOME PHONE ( )	WORK PHONE ( )
MAY WE CONTACT YOU AT HOME □ Yes □ N0		
EMERGENCY CONTACT	RELATIONSHIP	PHONE NO. ( )
EMPLOYER		OCCUPATION

PRIMARY CARE PHYSICIAN ORGANIZATION/GROUPADDRESS CITY STATE ZIP

WHO REFERRED YOU TO OUR GROUP?

IS YOUR PRIMARY CARE PHYSICIAN AWARE OF THIS REFERRAL?

□ Yes □ No □ N/A

REASON FOR TODAY'S VISIT

WERE YOU HURT AT WORK? IF YES. DATE OF INJURY CLAIM NO.

□Yes □ No

IS THIS YOUR FIRST REQUEST FOR SERVICES WITH OUR GROUP? IF NO, WHEN? WITH WHOM?

□Yes □No

Authorization for Assignment of Benefits and Release of Information and Financial Agreement of Benefits and Release of Information and Financial Agreement

I authorize Austin Psychiatric Alliance (APA), or any successor entity, to apply for benefits from my insurance carrier and further authorize payment directly to APA, or any successor entity, for the medical arid/or mental health benefits, if any, otherwise payable to me for services rendered by APA or any successor entity. I further authorize the release of medical/mental health information required by my insurance carrier or its designated review agent, required for payment of services provided, or (if applicable) my employer's workers' compensation insurance carrier in order to determine benefits to which I may be entitled, or to designate agents of APA or any successor entity. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked either by me or by the insurance carrier at any time in writing. I hereby assume financial responsibility for and agree to make payment in full to APA, or any successor entity, for all charges for services provided to the above-named patient not otherwise authorized or paid by my insurance carrier. I certify that the financial information given is true, accurate, and complete to the best of my knowledge. and further authorize APA or any successor entity to investigate any and all financial information given concerning this or related claims. Name of Insured.

Name of Insured, Patient, or Parent/Guardian _____ Signature _____ date _____

Patient Name:	Date:	DOB:

ADULT SELF REPORT

The following questions will help us in serving you. Please read and answer each question carefully.

Mental Health History

For what reason are you seeking treatment? _____

_____

_____

Have you ever been hospitalized for psychiatric concerns? ☐Yes ☐No

Have you ever been hospitalized for chemical abuse/dependence? ☐Yes ☐No

If yes, please list diagnosis, who made the diagnosis, when, and where: _____

_____

_____

Have you experienced something that was extremely upsetting to you? ☐Yes ☐No

If yes, please describe _____

_____

Are you experiencing:

Depression? ☐Yes ☐No

Loss of interest in activities? ☐Yes ☐No

Loss or increase in appetite? ☐Yes ☐No

Significant weight loss or gain? ☐Yes ☐No

Feelings of worthlessness or guilt? ☐Yes ☐No

Problems in concentration or decision making? ☐Yes ☐No

Thoughts about death, suicide, or self harm? ☐Yes ☐No

A period of at least four days in which you are so happy or excited that you get into trouble or others have become worried about you? ☐Yes ☐No

A period of at least four days of irritability or temper problems? ☐Yes ☐No

Racing thoughts or feel like you can't keep up with your thoughts? ☐Yes ☐No

Thoughts that others are "out to get you"? ☐Yes ☐No

Voices, visions, or sensations that others do not have? ☐Yes ☐No

Memory problems? ☐Yes ☐No

Anxiety? ☐Yes ☐No

Panic attacks/Fear? ☐Yes ☐No

Problems with binge eating? ☐Yes ☐No

Concerns about body image? ☐Yes ☐No

Persistent unpleasant thoughts? ☐Yes ☐No

Worries about physical health? ☐Yes ☐No

Patient Name:

Substance Use/Abuse History

Do you consume alcohol? ☐Yes ☐No

If yes, please describe how often and how much do you drink each time:

Do you use any illegal drugs (Cocaine, Amphetamines, other) ☐Yes ☐No

If yes, please list and time of last use:

Have you ever abused prescription medications or over-the-counter medications, such as pain medicine, narcotics, anxiety medications, tranquilizers, or sleeping medications? ☐Yes ☐No

If yes, please describe:

Have you ever participated in NA/AA or other self-help program? ☐Yes ☐No

How many caffeine products (colas or coffee) do you consume each day?

Do you use tobacco products? ☐Yes ☐No

If yes, please describe below what you use and how much:

Family History

Is there a family history of the following?

High blood pressure ☐Yes ☐No
Diabetes ☐Yes ☐No
Cancer ☐Yes ☐No
Heart disease ☐Yes ☐No
Seizure disorder ☐Yes ☐No
Other ☐Yes ☐No

If other please describe:

Is there a family history of mental conditions or chemical dependence such as:

Depression ☐Yes ☐No
Bipolar disorder ☐Yes ☐No
Schizophrenia ☐Yes ☐No
Learning problems ☐Yes ☐No
Suicide / suicide attempts ☐Yes ☐No
Attention deficit disorder ☐Yes ☐No
Anxiety disorder ☐Yes ☐No
Alcoholism ☐Yes ☐No
Drug addiction ☐Yes ☐No
Other ☐Yes ☐No

If other please describe:

Patient Name:

Medical History

Please list any current medical problems and the name of your treating physician:

Please list all current psychiatric medications:

Medications Dosage/Size How long Reason/Effect Physician

Please list all other current medications (prescription and over the counter)

Medications Dosage/Size How long Reason/Effect Physician

Are you allergic to medications? ☐ Yes ☐ No

If yes, please list _____

Have you ever experienced head trauma? ☐ Yes ☐ No

If yes, with loss of consciousness? ☐ Yes ☐ No

Have you ever experienced seizures? ☐ Yes ☐ No

If you are a woman, are you pregnant or plan to be? ☐ Yes ☐ No

If yes, please describe number of weeks pregnant or when you anticipate becoming pregnant _____

Have you ever been hospitalized for major surgeries or illnesses? ☐ Yes ☐ No

If yes, please list diagnosis, who made the diagnosis, when, and where: _____

Do you have any specific request or anything else that we should know about you to help make your treatment experience more successful? _____

Patient Name:

Other Information

Born and Raised:

Siblings: (Number and ages)

Highest level of education:

Marital Status: (number of marriages and years if applicable)

Children:

Occupation:

Years at current occupation:

Previous occupations:

Years in Austin:

Activities:

Austin Psychiatric Alliance

Please read carefully.

Effective Immediately

There will be a $100.00 charge per missed appointment and late cancellation.

The fee must be paid by the time of your next appointment.

When canceling, notice must be given more than 24 hours prior to the appointment.

As a reminder, your payment for service must be submitted at the time of your appointment. **No exceptions.**

Patient's Name: _____

Signature: _____

Date: _____

Austin Psychiatric Alliance - Financial Policy

Thank you for choosing Austin Psychiatric Alliance as your mental-health provider. We are committed to providing the best medical care possible. Please understand that payment of your bill is considered a part of your treatment. The following statement explains our Financial Policy, which we ask you to read, sign, and return to us prior to your treatment. You will also be provided with a copy of this policy.

- All patients should provide accurate and complete personal and insurance information prior to being seen by the doctor.
- All applicable co-pays and personal balances (both current and prior) are due at the time of service.
- We accept cash, personal checks, money orders, Visa, Master, and Discover card.

Regarding Insurance

We participate in a number of insurance plans. For some insurance a deductible may apply, and this is paid ***by the patient***. While we try to affiliate with as many plans as possible, changes can occur, so please verify any insurance changes each time you visit. In ALL cases we require that the guarantor (the person who is financially responsible) be ***personally*** liable for all balances not covered by insurance. It is your responsibility to understand and comply with any predetermination of benefits or referral requirements. Please be advised that some, and perhaps all, of the services provided may be non-covered services or may not be considered medically necessary under the Medicare Program or by other medical insurance companies.

Usual and Customary Rates

We are committed to providing the best treatment for our patients and we charge what we believe to be reasonable and customary fees for our region and specialty. While we usually accept insurance assignments of benefits; however, if your insurance company uses a different fee schedule, you may be responsible for any remaining balance.

Co-Pay Balances

Payment of co-pays is expected at the time of service. If you are unable to pay your co-pay at the time of service, you may be required to reschedule your appointment. Under special circumstances an appointment may be accepted without payment of the co-pay. In those cases, the co-pay will be added to your account balance and ***must*** be paid at your next visit. Co-pays are, under all circumstances, the patient's responsibility.

Missed Appointments

Please help us to serve you better by keeping scheduled appointments. If you have to miss an appointment, please provide us with 24 hours notice. If this is not possible, notify us as soon as possible. Missing an appointment without notice will result in a $50 charge being added to your account balance. This fee ***is not*** covered by insurance and will be due at your next appointment.

Returned Checks

Each check returned to us as unpaid by your bank will be charged a $35 fee. The fee will be added to your account balance, and your full account balance will be due in ***cash only*** at your next visit. This fee ***is not*** covered by insurance.

Past Due Accounts

We value you as a patient, and we will work with you to resolve any past due amounts. Past due accounts will be sent three requests for payment. If you are unable to pay your balance in full, please let us know so that we can arrange a payment plan with you. Failure to respond to these requests or to arrange to pay any past due amount will result in your account being referred to a third party for collection. This may also result in a suspension of services except on an emergency basis.

Miscellaneous Fees

We reserve the right to charge fees for miscellaneous services including, but not limited to, after hours refill requests, copies of medical records, or other services. You will be notified the amount of the fee before the service is rendered with the option to refuse the service. Fees accrued will be added to your account balance and will be due at your next appointment. Generally, these fees ***are not*** covered by insurance and will be your responsibility. Any questions or concerns about this policy or your account should be addressed to our office staff in person or by telephone.

Signature of Acknowledgment

I have read the Financial Policy. Further, I understand and agree to the Financial Policy. This policy supercedes any previous Financial Policy, and constitutes a part of my treatment.

_____ _____

Signature **Date**

AUSTIN PSYCHIATRIC ALLIANCE

CONSENT FOR TREATMENT

I give full consent for the completion of an evaluation and the provision of treatment as necessary until I otherwise notify AUSTIN PSYCHIATRIC ALLIANCE.

Signature: _____ Date: _____

CONSENT FOR TREATMENTOF CHILDREN OR DEPENDENTS

I certify that I have legal responsibility for _____
Including the specific right to initiate mental health treatment on their behalf. I give full consent of the completion of an evaluation and the provision of treatment as necessary until I otherwise notify AUSTIN PSYCHIATRIC ALLIANCE.

Signature: _____ Date: _____

STATEMENT OF RIGHTS AND RESPONSIBILITIES FOR PATIENTS

I have read and understand the Statements of Rights and Responsibilities for Patients. I may receive a copy for my records upon request.

Signature: _____ Date: _____