Atlantic Psychiatric CENTER

New Patient Information and Consent

The following form is to be completed by the patient
(or parent/guardian if patient is younger than 18 years-old)

Date completed: _____ **APC #:** _____

Patient's Name: _____ **SSN:**_____

Date of Birth: _____ **Current Age**: _____

Address: _____

Phone Number(s): (_____)_____ (_____)_____
Cell / Home Work

May we call you at home? ☐ Yes ☐ No May we call you at work? ☐ Yes ☐ No

Marital Status (circle one) ◯ Single ◯ Married ◯ Separated ◯ Divorced ◯ Widowed ◯ Living Together

Employer/School: _____ **Occupation**: _____

Primary Care Physician: _____ **Phone Number**: (____)_____

Insurance Information:
Health Plan/Insurance: _____ Policy #: _____
Subscriber Name: _____ Subscriber SSN: _____
Employer: _____ Referred by: _____

Emergency Contact:
Name: _____ Relationship: _____
Phone Number: (_____)_____ Phone Number: (_____)_____

Presenting Problem(s):
Please describe your reason for seeking services (include date/month problem(s) started: _____
_____
_____
Was there an event which made these issues or problems surface? If yes, please describe: _____
_____

Please indicate how your problems are affecting the following areas:

	No Effect	Little Effect	Some Effect	Much Effect	Significant Effect	N/A
Marriage / Relationships	☐	☐	☐	☐	☐	☐
Family	☐	☐	☐	☐	☐	☐
Job / School Performance	☐	☐	☐	☐	☐	☐
Friendships	☐	☐	☐	☐	☐	☐
Hobbies	☐	☐	☐	☐	☐	☐
Financial Well-being	☐	☐	☐	☐	☐	☐
Physical Health	☐	☐	☐	☐	☐	☐
Anxiety Level	☐	☐	☐	☐	☐	☐
Mood	☐	☐	☐	☐	☐	☐
Eating Habits	☐	☐	☐	☐	☐	☐
Sleeping Habits	☐	☐	☐	☐	☐	☐
Sexual Functioning	☐	☐	☐	☐	☐	☐
Ability to Concentrate	☐	☐	☐	☐	☐	☐
Ability to Control Temper	☐	☐	☐	☐	☐	☐
Spirituality	☐	☐	☐	☐	☐	☐

If your eating habits are affected, describe how: _____

_____

If your sleeping habits are affected, describe how: _____

_____

Medical History:

Allergies: _____

Please list any prescription medications you currently use (Name, dosage, frequency):

_____

_____

Please list any over-the-counter medications you currently use (Name, dosage, frequency): _____

_____

Please list any past or present conditions that you are currently or have been previously treated for: _____

_____

When did you last have a physical examination? _____

Who did you see? _____ _____

Name Phone Number

Family History:

Describe any medical or psychiatric conditions of your parents or siblings: _____

_____

_____

Psychiatric History:

Have you ever received psychiatric or psychological treatment of any kind before? ____

If yes, please answer the following:

What type of care did you receive? ____ Inpatient ____ Outpatient ____ Both

When were you in treatment? _____ How long? _____

Who was your therapist or doctor? _____

Did your doctor prescribe. medicine at that time? If yes, include name, dosage, frequency: _____

Substance Abuse History:

Have you ever abused drugs or alcohol? If yes, describe substance, amount, frequency, and dates: _____

_____

If yes, have you ever received substance abuse treatment of any kind? _____

Do you have a history of blackouts, seizures, or withdrawal symptoms? _____

_____

Please describe anything else you would like your clinician to know: _____

_____

_____

Patient Name: _____ APC #: _____

Confidentiality:

All information between clinician and patient is held strictly confidential unless:

1. The patient authorizes release of information with his/her signature.
2. Court order signed by a Judge.
3. The patient presents a physical danger to self.
4. In order to improve the quality of care, it may be necessary for professionals working at APC to discuss information regarding your case. That information is restricted only to associates of APC.
5. The patient presents a danger to others.
6. Child/Elder abuse/neglect is suspected.

In the latter two cases, we are required by law to inform potential victims and legal authorities so that protective measures can be taken.

Financial Terms:

Upon verification of health plan/insurance coverage and policy limits, your insurance carrier will be billed for you and your Provider will be paid directly by the carrier. The patient will be responsible for any applicable deductibles and copayments. If you are not eligible at the time services are rendered, you are responsible for payment.
For those without health plan/insurance coverage, payment arrangements should be made prior to your first visit.

Canceled/Missed Appointments:

A scheduled appointment means that time is reserved only for you. If an appointment is missed or canceled with less than 24 hours' notice, the patient will be billed according to the scheduled fee or according to the rules of the patient's health plan. If you do not schedule an expected appointment or do not reschedule a missed/canceled appointment, you will be called or contacted by mail at home.

Consent for Treatment:

I further authorize and request that Atlantic Psychiatric Center carry out mental health care services, examinations, treatments, and/or diagnostic procedures which now or during the course of my care as a patient are advisable. I understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement. I also understand that while the course of therapy is designed to be helpful, it may at times be difficult and uncomfortable.

Release of Information:
I authorize the release of information for claims, certifications/case management/quality improvement, and other purposes related to the benefits of my Health Plan. (Releases of information to providers, family, etc., requires separate form.)

Privacy Practices:
I hereby acknowledge receipt of the Notice of Privacy Practices.

I understand and agree to all of the above information.

_____
Patient (or Parent/Guardian) Name Printed

_____ _____
Patient (or Parent/Guardian) Signature Date

Atlantic Psychiatric CENTER

To Whom It May Concern:

The above listed patient is covered by the following insurance:

_____
Company/Plan

_____
ID Number

_____ (No) There is no other insurance.

_____ (Yes) There is other insurance.

What type of insurance is it?

_____
Company/Plan

_____
ID Number

What insurance is primary? _____

_____ _____
Signature of Insured Date

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ ***If yes***, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. _____ . _____ 3. _____ . _____

2. _____ . _____ 4. _____ . _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	$ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

CANCELLATION and NO-SHOW POLICY

It is our policy to charge a $50 fee if you do not show or reschedule your appointment at least 24 hours prior to you scheduled appointment time.

I have read and understand the above policy on No Shows/Cancellations:

_____

Patient (or Parent/Guardian) Name Printed

_____ _____

Patient (or Parent/Guardian) Signature Date