You must open this form directly in Adobe Acrobat Reader Complete the form and save it again. Email the completed form.

FAMILY PSYCHIATRIC SERVICES, LLC

PATIENT INITIAL INFORMATION FORM

New Patient   Name Change   Address Change   Insurance Change

Today's Date ____/____/____

Name:____

Last   *First*   *Middle*

Date of Birth: ____/____/____ Age: _____ Social Security #__________________________

Sex: Male Female

ADDRESS: Street ___________________________ Apt/Unit __________________________

City ___________________________ State ____________ ZIP _____________

Home Phone: ________________________ Work Phone: ________________________

Cell Phone: ________________________ E-mail: ____________________________________

Marital Status: Single Married Divorced Widowed Separated

Referred by: ____Phone: ________________

Therapist:____ Phone: ________________

Primary Care Physician: ______________________________ Phone ________________

Pharmacy:____ Phone: ________________

EMERGENCY CONTACT INFORMATION:

In case of emergency, who should be notified?________________________

Phone ________________

Do you give the office permission to discuss your treatment information (as appropriate) with family members?

YES NO If yes, please provide their names and phone numbers below.

Name: ______________________________________ Relationship: ___________________________

Phone # (day): ________________ Phone # (evening): _______________________

May we leave personal treatment information on your answering machine at home? (e.g. appointments/medication information)

YES NO

May we e-mail/text personal medical information to you? (e.g. if you request information from us about medication/treatment)

YES NO E-mail address: __________________________________/ Cell phone: ______________

RECEIPT OF NOTICE OF PRIVACY PRACTICES:

My signature below indicates that I have received and/or reviewed a copy of my physician's Notice of Uses and Disclosures of Protected Medical Information (Notice of Privacy Practices). I have been given the option of signing a separate Patient Consent Form.

Patient or Responsible Party Signature ____________________________________

Date ____/____/____

TREATMENT AGREEMENT:

It is the belief of this practice that symptoms are treated holistically, and therefore the APRN will not prescribe to patients not currently engaged in ongoing therapy. Therapy is available with the APRN and/or referrals to outpatient therapists are available. Initial patients will be given 30 days from the first session to engage in therapy for medication refills to be given.

FINANCIAL POLICY:

This office participates in the following insurance plans: Aetna, Anthem, and Cigna. You will be responsible for paying your annual deductible, copayment and any non-covered charges at the time of visit. Fee-for-service charges are as follows: *Initial Consultation:* $250.00, *Medication follow-up and/or therapy visits:* $150.00. Full payment is required at each visit. There will be a $50.00 charge for returned checks and cash/money orders will required thereafter for further visits. Please note that accounts three months past due will be sent to Eastern Accounts System of Connecticut, Inc. for collection of balance remaining.

CANCELATION POLICY:

It is important that we are notified of appointment changes so that we can schedule another patient in your place if needed. Please be courteous and **notify the office timely and within at least 24 hours so you will not be charged the late cancel/no show fee of $150.00**. (Fee will be waived in emergency/unexpected situations at the discretion of the APRN). **Please note that the office has a three time no show/cancellation policy stating that if a patient is habitually missing appointments without notice or is chronically tardy/frequently canceling visits, we have the right to terminate services due to nonparticipation in treatment.*

SAFETY CONTRACT:

Please note that Family Psychiatric Services, LLC is devoted to providing a holistic approach to mental health services. This means that together we will explore traditional and alternative treatment options so that we can help alleviate any symptoms you are having. The therapeutic relationship is an important component in healing, and therefore it is encouraged that you communicate freely any concerns, fears, and/or thoughts about therapy/medication that you are having. All communications with the APRN/therapist are confidential, however for yours and others safety, an exception will be made if you express any intent on harming yourself or others.

Patient or Guardian Signature ___________________________________

Date ____/____/____