Psychiatry Delaware, LLC
Patient Registration Form

Welcome! Please fill out the information below so that we can better care for you.

Patient Information

▫ Dr. ▫ Mr. ▫ Mrs. ▫ Ms. ▫ Jr. ▫ Sr. ▫ Other _____

Last Name _____ First Name _____ Middle _____

Date of Birth _____/_____/_____ Marital Status ▫ Married ▫ Single ▫ Other

Social Security Number _____-_____-_____ ▫ Female ▫ Male

Address _____

City, State ZIP _____

E-mail Address: _____

Phone # Home: _____ Work: _____
Cell: _____ Best Number ▫ Home ▫ Work ▫ Cell

My personal information regarding mental health, treatment, or payment may be:
▫ left on my answering machine/voice mail
▫ left with another person answering. Please list name(s) _____
▫ not be left with any person or on any answering machine.

Preferred Language ▫ English ▫ Spanish ▫ Other_____

Ethnicity ▫ Hispanic/Latino ▫ Non-Hispanic or Latino ▫ Prefer not to answer
Race (Check all that apply)
▫ Caucasian/White ▫ Black/African American ▫ Hispanic/Latino ▫ Refused
▫ Native American/Eskimo Aleutt ▫ Asian/Pacific Islander ▫ Other _____

Emergency Contact and Information Sharing

Emergency Contact Name _____

Relationship _____ Phone Number: _____

My health information can be shared with this individual ▫ Yes ▫ No
Other individuals my health information can be shared with (please list name, telephone number and relationship):

_____

_____

My health information may not be shared with: _____

Last Name _____ **First Name** _____ **Date of Birth** _____/_____/_____

Insurance Information

▫ Same as Above (check this box and skip this section)

▫ Other Responsible Party (please fill out the information below if you are not the subscriber)

Last Name _____ First Name _____ Middle _____

Date of Birth _____/_____/_____ Relationship _____

Social Security Number _____-_____-_____ Female Male

Phone # Home: _____ Work: _____
Cell: _____ Best Number Home Work Cell

Address _____

City, State ZIP _____

Pharmacy Information

Local Pharmacy Name_____
Pharmacy Address _____
Phone # _____

Mail Order Pharmacy Name _____
Pharmacy Address _____
Phone # _____

I agree that the information supplied on the two pages of this form is accurate and up-to-date to the best of my knowledge.

Also, I have received/was offered a copy of Psychiatry Delaware's Privacy Practices. This notice describes how my health information may be used or disclosed and explains my right as a patient. I understand that I should read this document carefully and that it may be changed at any time. I may obtain a copy of this notice by requesting it in person or calling the practice.

I consent to evaluation and treatment by any provider affiliated with Psychiatry Delaware. I hereby authorize release of medical information that is necessary for my further treatment and for the purpose described in Psychiatry Delaware's Privacy Practices.

Patient Name (please print) Signature of Patient or Responsible Party

_____ _____

Date: _____/_____/_____

Psychiatry Delaware
Andrew Donohue, D.O.
Dolores Onorato, MSW, LCSW
1415 Foulk Road
Suite 104
Wilmington, Delaware 19803

AUTHORIZATION FOR RELEASE OF MENTAL HEALTH RECORD

(Also known as Protected Health Information)

PATIENT NAME _____ Date of Birth _____

Address (Mailing) _____ Phone _____

I authorize Psychiatry Delaware, LLC to use or disclose information from my mental health record, which may include information about psychiatric diagnosis and treatment and substance abuse issues to:

Primary Care Doctor/Specialist's Name: _____

Address: _____

Phone: _____

Dates of Treatment (please check one): ☐ All ☐ Specific date: _____

Information to be released (please check one): ☐ All ☐ Specific date: _____

Purpose of Disclosure (please check one: ☐ Medical Care ☐ Other: _____

I understand that, unless withdrawn, this authorization will expire 180 days from the date of signature. A photocopy of this form will be considered as valid as the original. 2. I understand that I may revoke this authorization at any time by notifying Psychiatry Delaware, LLC at the address indicated above, in writing, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it. 3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information and mental health information. 4. I understand that my refusal to sign this Authorization will not jeopardize my right to obtain present or future treatment for psychiatric disabilities except where disclosure of the information is necessary for the treatment. 5. My health care and payment for my health care at Psychiatry Delaware, LLC will not be affected if I do not sign this form. 6. I understand that I can request a copy of this form after I sign it. 7. By signing below, I acknowledge that I have read and understand this Authorization.

_____ Signature of Patient or Parent/Legal Guardian/Authorized Person

_____ Date

_____ Relationship to Patient

Psychiatry Delaware
1415 Foulk Rd, Suite 104
Wilmington, DE 19803

Patient Policies
(Please read and sign)

Emergencies/After Hours

- If you are experiencing a true medical emergency, have taken an overdose, or have harmed yourself in any way, DIAL 9-1-1 IMMEDIATELY.
- For less urgent issues, please call the doctor on call, 302-235-3725
- Delaware's Crisis Intervention provides 24 hour help for people with severe mental health problems. They can be reached at 302-577-2484 or 800-652-2929.
- If you require an emergency appointment, provisions will be made for an emergency appointment to be conducted the next day, if possible.

Payment Policies

- Payment for services, including insurance co-payments, is due at the time of service.
- If you do not have insurance you will be charged the full rate of services.
- Checks returned for insufficient funds will result in an additional fee to the client of $20.00.
- Unless arrangements are made for a payment plan, all accounts that are outstanding for **greater than 90 days** will be sent to our collection agency.

Appointment Cancellations

- If the appointment is cancelled with at least 48 hours' notice, the client will not be penalized.
- A first-time cancellation within 48 hours of the scheduled appointment will not be penalized.
- A second cancellation within 48 hours of the scheduled appointment will result in a fee of $50.00. *Your insurance company will not reimburse you for missed appointment/late notice fees.*
- A third cancellation within 48 hours of the scheduled appointment will result in a fee of $100.00. *Your insurance company will not reimburse you for missed appointment/late notice fees.*
- A fourth or greater cancellation within 48 hours of the scheduled appointments will result in a fee equal to the full rate of service. *Your insurance company will not reimburse you for missed appointment/late notice fees.*
- EXCEPTIONS will be dealt with on a case-by-case basis and are at the discretion of the practice.

I agree with the patient policies described above:

_____ _____

Name Date