**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 \_\_\_ I\_\_\_ I\_\_\_**

**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 \_\_\_\_\_ I\_\_\_\_\_ I \_\_\_\_\_ 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

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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

| 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): 󠁾 AIl 󠁾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. 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 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** and leave a message. The doctor on call will get a voice message and call you back.
* 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 you miss your initial appointment you will be required to pay ***$300.00*** no show fee prior to rescheduling.
* If the appointment is cancelled with at least 48 hours' notice, the client will not be penalized.
* Each 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.
* EXCEPTIONS will be dealt with on a case-by-case basis and are at the discretion of the practice.

Paperwork

* Paperwork does not constitute a medical or psychiatric emergency.
* We are usually willing to fill out paperwork for an established patient **during your session** free of charge. You must present the paperwork before or at the beginning of the session. If the paperwork is too extensive to be completed during your session, there may be an additional charge.
* Any additional paperwork carries a charge of ***$50 - $100***. This includes short and long term disability paperwork, FMLA forms and legal paperwork.

Prescriptions, Refills, Samples, and Prior Authorizations:

* Prescription refills are provided to you at our appointment. If you need a refill before your next visit, please call our office and leave a message. Refills are only given to get you through until your next scheduled appointment, so keeping your follow up appointment is important. A fee of $25 could be charged for requesting a refill before your next scheduled appointment. Our office has three days to complete your refill requests. It is important to contact the office before you have run out of your medications. **NOTE: Controlled substances WILL NOT be called in. Exceptions to this rule are rare and at the prescriber’s discretion.**
* We sometimes offer you samples to help you try a new medications before you purchase it. Remember that samples are not a long term way to fill your prescription. We will not always have samples of your medications.
* Prior Authorizations, when applicable, are required by your insurance company, not your doctor. Health Insurance companies developed this process in order to limit patients’ access to expensive medication that may not be necessary.
* We make reasonable efforts to convince your insurance company to authorize payment for the prescribed medication, but ultimately your insurance company decides whether or not they will pay for the medicine. This process can take up to ten working days. You may need to return to the office for another visit to discuss options if a prior authorization is denied by your health company.

Discharge

* If you are discharged from the practice, it means you can no longer schedule appointments, obtain medication refills, or consider our practice to be your mental health provider. You will need to find another doctor at another practice.
* We will send a notification letter to your last known address, if you are discharged from our practice.
* Common reason for discharge:
  + Failure to keep appointments and frequent no shows
  + Non-compliance, which means you won’t follow physician instructions about important health issues
  + Abusive to staff
  + Failure to pay your bill

I agree with the patient policies described above:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name Date**

**About our no show and late cancellation policy:**

There is a national shortage of psychiatrists and qualified mental health practitioners.

Our practitioners’ time is valuable.

We also value your time and do everything we can to run on-time and keep you from waiting in our waiting room. We do not routinely double book patients and we set aside your appointment time for you and you alone.

We expect that in return, you will value our time.

We expect you to come in when you have an appointment and give adequate time (two business days) if you have to cancel.

If you miss your appointment or cancel without giving us adequate time, this means that the time we have set aside to meet you is wasted.

We change you (not your insurance company) a fee of $50.00 for this wasted time, if you miss appointments or cancel without adequate notice.

We consider (rare) exceptions on a case-by-case basis.

We believe this policy is fair and necessary.

Reasonable people sometimes disagree and if you disagree with the policy, that is reasonable, but we may not be the right practice for you.

If you want to become/remain our patient, please confirm that you are aware of this policy by signing and dating below:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name Date