Psychiatry Delaware LLC

1415 Foulk Rd, Suite 104 Wilmington, DE 19803

Patient Registration Form

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

Patient information

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: _____

Would you like to sign up for our patient portal? ☐ Yes ☐ No

(If you choose not to sign up, you will not receive an appointment reminder.)

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:

_____

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 first 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 the 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: _____ /_____ /____

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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:

Person/Provider/Organization: _____

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. 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

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Patient Policies (Please read and sign)

Emergencies/After Hours **____Initial**

- If you are experiencing a true medical emergency, have taken an overdose, or have harmed yourself in any way, DIAL 9-1-1. IMMEDIATELY.
- Delaware's Crisis Intervention provides 24 hours help for people in crisis. They can be reached at **302-577-2484** or **800-652-2929**.
- For less urgent issues that can not wait until the next business day, 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.
- If you require an emergency appointment, please leave a message on **302-478-1450**.

Payment Policies **____Initial**

- Payment for services, including insurance co-payments and deductibles, is due at the time of service.
- It is your responsibility to update any insurance changes or payment methods to your account. All unpaid balances/insurance denials will be patient responsibility.
- If you do not have insurance you will be charged the full rate of services.
- *You do have the option of keeping a credit card on file for any outstanding balances.*
- Checks returned for insufficient funds will result in an additional client fee 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 No-Show and Cancellation Policy **____Initial**

- All appointments must be cancelled 1 business day prior to the scheduled appointment.
- If you no-show your scheduled appointment, you will be charged **$75.00.**
- If you cancel your appointment less than 1 business day, you will be charged **$50.00.**
- It is your responsibility to know the date and time of your appointment.
- Your insurance company will not reimburse you for missed appointment/late cancel fees.

Paperwork **____Initial**

- Paperwork does not constitute a medical or psychiatric emergency.
- We will fill out most 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 paperwork needed between sessions 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 **____Initial**

- Prescription refills are provided to you at your 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 four days to complete your refill requests. It is important to contact the office before you have run out of your medications. All refills must be requested during business hours. **NOTE: Controlled substances can not be called in.**
- Our office does not provide early refills. Medications must be taken as prescribed.
- Medications changes must be discussed and approved by the doctor at your next scheduled appointment.
- 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 **____Initial**

- 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 (one full business day) 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 with you is wasted.

We charge you (not your insurance company) a fee for this wasted time, if you miss appointments or cancel without adequate notice. The Fee is $75.00 for a no show and $50.00 for canceling less than 24 business hours before your appointment.

We believe this policy is fair and necessary.

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

If you want to become/remain our patient, please confirm that you will abide by this policy by signing and dating below. By signing, you are agreeing to pay all fees if you fail to come to an appointment or cancel with inadequate notice.

_____ _____

Patient Name **Date**

Psychiatry Delaware

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(Please read and sign)

PATIENT CONTRACT BETWEEN PSYCHIATRY DELAWARE AND PATIENTS WHO ARE PRESCRIBED LONG-TERM CONTROLLED SUBSTANCES

The purpose of this contract is to protect your access to controlled substances and to protect our ability to prescribe to you.

The long-term use of such substances as benzodiazepine tranquilizers, barbiturate sedatives, sleep-hypnotics and stimulants is controversial because the medications can be helpful or potentially problematic and detrimental over time. Patients who are prescribed these drugs have some risks of developing an addictive disorder, or suffering a relapse of a prior addiction. The extent of this risk is not certain.

Because these drugs can be abused by the patients who receive them, or by others, it is necessary to observe strict rules when they are prescribed. For this reason, we require each patient receiving long-term treatment with these medications to read and agree to the following policies.

It is agreed by you, the patient, as consideration for, and a condition of, the willingness of the physician whose signature appears below to consider prescribing or to continue prescribing controlled substances to treat your psychiatric condition.

1. All applicable controlled substances must come from a physician in this office. My controlled substances will come from the physician whose signature appears below, or during his or her absence, by the covering physician unless specific authorization is obtained for an exception.
2. If I take opiate pain medication (a class of medication that we do not prescribe) I will inform my doctor at Psychiatry Delaware and consent to allow my doctor and the doctor prescribing the pain medication to communicate.
3. I will inform my physician of any current or past substance abuse, or any current or past substance abuse of any member of my immediate family.
4. I will obtain all controlled substances from the same pharmacy. Should the need arise to change pharmacies; I will inform the office. The pharmacy I am selecting is:

   Name: _____ Telephone#: _____
5. I will inform the office of any new medications or medical conditions, and of any adverse effects I experience from any or the medications that I take.
6. I agree that my prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professions who provide my health care for purposes of maintaining accountability.

7. I will not allow anyone else to have, use, sell, or otherwise have access to these medications.
8. I understand that tampering with a written prescription is a felony and I will not change or tamper with my doctor's written prescription.
9. I will take my medication as prescribed and I will not exceed the maximum prescribed dose.
10. I understand that these drugs should not be stopped abruptly, as withdrawal syndromes will likely develop.
11. I will cooperate with unannounced urine or serum toxicology screens as may be requested.
12. I understand that the presence of unauthorized substances may prompt referral for assessment for a substance abuse disorder.
13. I understand that these drugs may be hazardous or lethal to a person who is not tolerant to their effects, especially a child, and that I must keep them out of reach of such people for their own safety.
14. I understand that medications may not be replaced if they are lost, damaged, or stolen. If any of these situations arise that cause me to request an early refill of my medication, I will be required to complete a statement explaining the circumstances. At that time a determination will be made as to whether I may receive an early refill. If I request an early refill secondary to lost, damaged or stolen prescriptions twice within a year, I will possibly be discharged from the practice.
15. If the responsible legal authorities have questions concerning my treatment, as may occur, for example, if I obtained medications at several pharmacies, all confidentiality is waived and these authorities may be given full access to my full records of controlled substances administration.
16. I understand that failure to adhere to these policies may result in cessation of therapy with controlled substance prescribing by this physician or referral for further specialty assessment.
17. I will keep my scheduled appointments in order to receive medication renewals. No refills will be given at night or on weekends or if you missed your appointment.
18. I understand that any medical treatment is initially a trial, and that continued prescription is contingent on whether my physician believes that the medication usage benefits me.
19. I have been explained the risks and potential benefits of these therapies, including, but not limited to psychological addiction, physical dependence, withdrawal and overdose. I also understand that the medications impair my ability to drive or operate machinery. I will not drive, etc, under illegal or unsafe conditions.
20. I may be required to participate in a specific group or treatment as an alternative means of learning anxiety reduction skills as a condition of continuing to receive this medication.
21. I affirm that I have full right and power to sign and be bound by this agreement, and that I have read, understand and accepts all of its terms
22. I am aware that attempting to obtain a controlled substance under false pretenses is illegal.
23. Any deviations from the terms of this contract may result in my discharge from the practice at any time. In this event, I will be referred to a substance-abuse treatment facility or another appropriate agency.

_____	_____
Physician Signature	**Patient Signature**
_____	_____
Date	**Patient Name (Printed)**