UNIVERSITY PSYCHIATRIC ASSOCIATES, PA

Registration Form

PATIENT INFORMATION

Patient: _____ Social Security #: _____
Last First MI Driver's License#: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone#: _____ Sex: __ Birthdate: _____ Age: __ Marital Status: _____
Cell Phone#: _____

Patient's Employer: _____ Telephone #: _____
Address: _____ City: _____ State: _____ Zip: _____

Family Physician: _____ Telephone#: _____
Therapist: _____ Telephone #: _____

Referral Source: _____
Address: _____

Emergency Contact: _____ Telephone #: Work _____ Home _____

BILLING INFORMATION

Person Responsible for bill: _____ Social Security #: _____
Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Telephone #: _____
Address: _____ City: _____ State: _____ Zip: _____

INSURANCE INFORMATION (***Primary***)
Insured's Name: _____ Relationship to Patient: _____
Insured's Employer: _____Policy Hold DOB: _____
Insurance Company: _____ ID#: _____
Claims Address: _____ Claims Phone #: _____
Insurance Authorization #: _____ SS#_____

INSURANCE INFORMATION (***Secondary***)
Insured's Name: _____ Relationship to Patient: _____
Insured's Employer: _____Policy Hold DOB: _____
Insurance Company: _____ ID#: _____
Claims Address: _____ Claims Phone #: _____
Insurance Authorization #: _____ SS#_____

PERSONAL INFORMATION

Reason for Visit: _____ **is this disability related?** _____

Current Medications:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Allergies: _____ Who lives with you: _____

Do you smoke: _____ How much: _____ How many years: _____
Do you drink: _____ How much: _____ How many years: _____
Do you do illegal drugs: _____ How much: _____ How many years: _____

Describe your job: _____

University Psychiatric uses a computerized call service for a ***courtesy reminder*** for appointments.
Best number for courtesy reminder call: _____
Okay to leave a message at this number? Yes ___ No ___

CONSENT FOR TREATMENT

I give my consent for this office to provide mental health treatment for me or my child. This consent covers the treatment by my psychiatrist and/or individual therapist.
Client's Signature: _____ Date: _____
Legal Guardian Signature: _____ Discharge Date: **See Treatment Plan**

CONSENT FOR TREATMENT OF MEDICAL AND PSYCHIATRIC EMERGENCIES

I give my consent for this office to initiate first aide measures, to contact my primary care physician, or alert the emergency medical system. I also consent for my emergency contact to be notified.
Client's Signature: _____ Date: _____
Legal Guardian Signature: _____ Discharge Date: **See Treatment Plan**

ASSISGMENT OF BENEFITS

I authorize payment of medical benefits to *University Psychiatric Associates*, *PA* for services rendered. I assume responsibility for the balance in full. I authorize the release of any medical information necessary to process this claim. I also request payment of government benefits to *University Psychiatric Associates, PA*. I understand that if this account is assigned to an attorney for collection and/or suit, *University Psychiatric Associates, PA* shall be entitled to reasonable attorneys fees and costs for collection and that information regarding this account may be released.

Signed: _____ Date: _____

UNIVERSITY PSYCHIATRIC ASSOCIATES, PA
8320 University Executive Park Drive, Suite 104
Charlotte, North Carolina 28262

FINANCIAL POLICY

We hope you understand that our credit and collection policies are a necessary part of assuring the financial resources needed to maintain this practice for our patients. Because statement and billing costs have become so expensive and because we do our best to keep medical costs down, it is the policy of this practice to request payment in full at the time of services rendered.

MANAGED CARE: **If you are insured by an HMO or PPO with which we participate, all copayments are required to be paid in advance. If this is not possible, we must reschedule your visit. If you do not have an insurance card, charges for the services will be due at the time of services. In order for us to file a claim, we must have a copy of your insurance card at the time of service as there are time limits for filing claims with insurance companies. Should you elect to see a provider for a service not covered by your insurance company, you will be responsible for payment for the service in full.**

METHOD OF PAYMENT: We accept Visa, MasterCard, Discover, personal checks, money orders and cash.

RETURNED CHECKS: A fee of $25.00 will be charged for all returned checks!

MISSED APPOINTMENTS: We ask that if you cannot keep a scheduled appointment that you cancel at least 24 hours prior to that appointment. Failure to do so will result in a ***LATE CANCELLATION OR MISSED APPOINTMENT FEE* of $50.00.** These fees are not reimbursable by any insurance company and are the direct responsibility of the patient.

FORMS: Any forms needed for disability, attorneys, family medical leaves, etc., not related to your management care insurance, you will be charged at a rate commensurate with the time required completing the forms.

PAYMENT OF ACCOUNT: If unusual circumstances should make it impossible for you to meet our credit terms, we invite you to call or personally discuss the matter with our billing staff. This will avoid any misunderstandings and enable you to keep your account in good standing. Should your account be turned over to an agency for further collection procedures, a 35% fee will be charged to your account.

Signature of Understanding: I have read and understand the above financial policy. I accept responsibility of payment for services as outlined above.

_____ _____
Patient/Guardian's Signature Date

_____
Print Patient's Name

UNIVERSITY PSYCHIATRIC ASSOCIATES, PA

CLIENT RIGHTS AND TREATMENT RULES

Acknowledgement of receipt of a copy of their
notice of policies and practices to protect the privacy of your health information

I acknowledge that I was given a copy of UPA's notice of policies and practices to protect the privacy of my health information. I understand these policies and practices to protect the privacy of my healthcare.

I received a written summary of the Client Rights and Treatment Rules. I was provided an opportunity to ask questions. I understand my rights. I understand the treatment rules and possible penalties for violation of these rules. I agree to comply with these rules.

_____
Print Patient Name

_____
Signature

_____
Date

_____
Witness Signature

Consent for Use and Disclosure of Protected Health Information

I, _____ consent to having my protected health information used and disclosed to carry out treatment, payment and healthcare operations. I received UPA's Notice of Policies and Practices to Protect the Privacy of Your Health Information. I was provided an opportunity to ask questions. Please read this notice before signing this consent.

I understand:

A. UPA has the right to change their privacy policies and practices at any time and how UPA will notify me of these changes.
B. I have the right to request restriction on the use and disclosure of my protected health information, but UPA does not have to agree to my request. If UPA agrees to my restriction request, it is binding until one of us notifies the other in writing of a change.
C. I have the right to revoke this consent in writing at any time except when UPA has already acted.

_____ _____
Client's Signature Date