Danbury Psychiatry Consultants, LLC
NEW PATIENT REGISTRATION FORM

Title: _____ First Name: _____ MI: _____ Last Name: _____

Home Address: _____ Apt/ Suite: _____

City/State/Zip: _____ Date of Birth: _____

Sex (M/F): _____   Circle Marital Status: Single Married Divorced Legally-Separated Widow

Social Security Number: _____ Preferred Reminder By: ___Text ___Email

Home Phone (H): _____ Cell Phone (C): _____ Preferred (H/C): _____

Email: _____

Ethnicity: Please check only one:

☐   Hispanic or Latino
☐   NOT Hispanic or Latino
☐   Patient Declined to
     Answer

Race: Please check only one:

☐   American Indian or
     Alaskan Native
☐   Asian
☐   Black or African
     American
☐   Native Hawaiian or
     Other Pacific Islander

☐   White
☐   Other
☐   Patient Declined to
     Answer

Preferred Language: _____ (English or Other-please specify)

Employer: _____ Work Phone: _____

(You are responsible for keeping the office informed of any insurance changes in advance of appointments).

Insurance: Self Pay (circle) or Insurance Carrier: _____

Responsible Party:

Policy Holder Name (if not self): _____ Relationship _____

Address: _____

PH Social Security #: _____ PH Date of Birth: _____

PH Phone Number: _____

Send bill to Patient: _____ or Responsible Party: _____?

Emergency Contact:

Name: _____ relationship: _____

Contact Phone Number: _____

Primary Care Physician (PCP): _____ PCP City/State: _____

How did you hear about our practice? _____

ASSIGNMENT OF BENEFITS

I hereby authorize my treatment provider(s) to apply for benefits on my behalf for covered services rendered. I request that payments from my insurance company be made directly to my provider(s) or to Danbury Psychiatry Consultants LLC, who may in some cases accept assignment. If I receive any payments from my insurance company in error, I will notify Danbury Psychiatry Consultants for further investigation. If claims are denied for any reason, I will be responsible for the full session fee. I agree to obtain pre-certification from my insurance company for my initial appointment as required. I certify that the above information I have reported with regard to my insurance is correct. I permit a copy of this authorization to be used in place of the original.

This authorization may be revoked by either me or my insurance company at any time in writing. I hereby authorize the use of this signature for billing my insurance company. I agree to be personally responsible (or where appropriate, allow my family/significant other to be responsible) for payment of all charges due Danbury Psychiatry Consultants if they are not covered by my insurance carrier and/or the provider is our-of network.

Patient/Guardian Signature: _____ Date: _____

CONSENT AND ACKNOWLEDGEMENT FORM

I provide consent for psychiatric evaluation and treatment rendered by the provider(s) of Danbury Psychiatry Consultants LLC in their practice of behavioral medicine. I have received a written copy of the office policies, read them, and agree to comply with their recommendations. I also acknowledge receipt of the Patient-Doctor Contract and understand the mutual obligations. I am free to stop taking any recommended medication without forfeiting the right to be re-evaluated by the provider. However, I also understand that it is not recommended that I stop any medication abruptly or without medical supervision. Continued lack of compliance with my doctor's recommended plan would be a concern and may result in a referral. I also understand that I am free to transfer my care at any point without prejudice.

Danbury Psychiatry Consultants will take precautions to protect my confidentiality and privacy. Some uses and disclosures are permitted. Danbury Psychiatry Consultants may release protected health information concerning my evaluation and treatment as judged necessary for routine practice operations: carrying out treatment, obtaining payment, or conducting certain healthcare operations. Recipients of such information may include another physician treating me, my insurance company, and other reimbursement agencies identified by me. Protected health information disclosed by Danbury Psychiatry Consultants may include HIV/AIDS related information, psychiatric and other mental health information, alcohol treatment information, as long as such information is used or disclosed in accordance with Connecticut law. Other disclosures may require you to provide specific authorizations.

Insurance cards must be presented at every visit. I understand that if my insurance changes in any way, it is my responsibility to inform the office and provide the new insurance information. If there is an unavoidable delay in providing the new information, it still must be done within 45 days of the date of service. Failure to do so will probably result in claims being denied and payment for services will become my responsibility.

I understand that this consent is effective as long as Danbury Psychiatry Consultants maintains my protected health information.

By Signing below, I understand and acknowledge that I have read and understand this consent.

PRINT NAME of Patient:_____

Patient Signature: _____

PRINT NAME of Guardian/Responsible Party (if not self): _____

*Signature of Guardian/Responsible Party: _____

Date: _____

*If signed by the patient's guardian/responsible party, describe the legal authority of the representative to act on behalf of the patient. (Danbury Psychiatry Consultants may request proof of guardianship or power of attorney).

_____

AUTHORIZATION TO RELEASE/RECEIVE INFORMATION

This release is to authorize *Danbury Psychiatry Consultants* to release, communicate and receive written and verbal information including Medical and Psychotherapy records, Psychiatric, Psychological, or Education Evaluations, School records, intake and/or discharge summaries, and treatment plans from the record of:

Patient:_____

To/From:

Primary Care Doctor_____

School_____

Insurance Company_____

Therapist_____

Other_____

Other_____

It is my understanding that the information may be used for clinical study, diagnosis, treatment and/or condition for payment by third party payers.

I understand that the records to be release may contain information pertaining to Psychiatric, drug and/or alcohol abuse treatment, and may also contain confidential HIV (AIDS) related information.

I understand that I may withdraw this consent at any time prior to the release of the above information.

If not revoked by me, this authorization will expire 90 days from the date of discharge.

_____   _____
Signature of Patient   **Signature of parent or guardian**
(All patients 16 years and older.   (If patient is under 18 years)
All patients 14 years and older if
substance abuse diagnosis)

_____   _____
Date   Signature of witness

Prohibition of Re-disclosure:
This information is protected by Federal Law. Federal regulation (42 CRF Part 2) prohibits further disclosure of this information except with the specific written consent of the person with whom it pertains. A general authorization for the release of medical or other information if held by another party is not sufficient for his purpose. Federal regulations state that any person who violates any provision of this law shall be fined not more than $500 in the case of a first offense and not more than $5,000 in the case of each subsequent offense.

AUTHORIZATION TO RELEASE INFORMATION within Families

To be complete if patient is over 18 years old and there is any other person that you wish to be able to inquire about either your clinical history or your billing status. Without permission, no member of *Danbury Psychiatry Consultants* should answer questions posed even by a family member (spouse, parent, other relative) about your medical status, your medications, or your billing.

Patient: _____

This release is to authorize Danbury Psychiatry Consultants to release or communicate written or verbal information regarding my account to/with:

1-Name: _____ Phone: _____ Relationship: _____

2-Name: _____ Phone: _____ Relationship: _____

3-Name: _____ Phone: _____ Relationship: _____

The information that may be shared is indicated below:
For WHOM (1, 2, 3) - Check all those that apply

_____	_____ Psychiatric Records and Treatment Plans
_____	_____ Prescription Information, including pick-up of scripts
_____	_____ Billing Information: insurance, charges, payments, balances
_____	_____ Appointment Information: inquiring, making, changing appointments

OR CHECK HERE ____ if **NO information is to be shared** (except as provided for by HIPAA)

I understand that if I authorize the release of records, those records may contain information pertaining to psychiatric, drug and/or alcohol abuse treatment, and may also contain confidential HIV (AIDS) related information.

I understand that I may withdraw this consent at any time prior to the release of the above information.

If not revoked by me, this authorization will expire 90 days from the date of discharge.

_____
Signature of Patient

_____
Date

Credit Card on File Authorization

Please complete this form if you would like **Danbury Psychiatry Consultants** to keep your credit card on file for future payments. You may elect to provide us with credit card information separately for each payment.

Patient Name (s): _____

_____

Information to be completed by the cardholder (please print):

Cardholder Name: _____

Card Number: _____

Card Type: Visa MasterCard American Express Discover (please circle)

Expiration Date: _____ (MM/YY)

Security Code: _____ (3 digit code on back)

Billing Zip Code: _____

Phone: _____

HSA card: (yes/no) _____

I, _____, authorize **Danbury Psychiatry Consultants** to charge the above credit card account for payments owed to my account for services rendered at their office. I agree to update any information regarding this account. The above information is complete and correct to the best of my knowledge.

In the event that I have a balance more than 60 days past due, I authorize *Danbury Psychiatry Consultants* to charge that balance to this card. I understand that the office will call to inform me, or leave a message on my answering machine, at least 24-hours prior to running the card.

_____   _____
Cardholder Signature   Date