Valley Psychiatric Associates, P.C.

ADULT PATIENT INFORMATION

Name _____ DOB _____

Address _____ City _____ State _____Zip _____

Home Phone _____ Cell Phone _____ Work _____

Marital Status: S M D W Sex: M F Social Security Number _____

Place of Employment _____ How Long? _____

Referred by_____

BILLING PARTY IF OTHER THAN PATIENT

Billing Party's Name _____ DOB _____

Billing Party's Address _____ City _____ State _____Zip _____

Home Phone _____ Cell Phone _____ Work _____

Marital Status: S M D W Sex: M F Social Security Number _____

Place of Employment _____ How Long? _____

Relationship to Patient _____

INSURANCE

Primary Insurance Company _____ Subscriber Employer _____

Contract Number _____ Group Number _____

Subscriber Name _____ DOB _____ SSN _____

Subscriber Address _____ City _____ State _____Zip _____

****Please note** any individual who comes into this office to be seen is responsible for payment at the time of service. It is your responsibility to arrange reimbursement from any other billing parties.**

Insurance Authorization and Assignment

I understand that I am financially responsible for any medical service at the time of the service. I authorize my insurance carrier to pay Valley Psychiatric Associates, P.C. any assigned claims filed by them and authorize for release of medical information requested by my insurance company.

Date _____ Signature _____

I have received the Privacy Notice. Date_____ Initial _____

*V*ALLEY *P*SYCHIATRIC *A*SSOCIATES, *P.C.*

AUTHORIZATION FOR CORRESPONDENCE

I hereby authorize Valley Psychiatric Associates to contact me for purposes of scheduling, rescheduling, verifying appointment, or for any other reason affecting my treatment.

You may:

____ send mail to my home

____ call me at home at phone number: _____

____ leave a message on my answering machine

____ leave a message with whomever answers the above telephone number

____ call me at work, but speak only with me at phone number: _____

____ call my cell phone at phone number: _____

____ leave a message on my cell phone voicemail (if applicable)

I give Valley Psychiatric Associates permission to contact my:

Primary Care Physician ___ Yes* ___ No

Psychiatrist/Other Therapist ___ Yes* ___ No

School/Employer ___ Yes* ___ No

*Please complete the appropriate Release of Information form.

I have read the above authorization and understand the same.

_____ _____
Signature Date/Time

_____ _____
Witness Date/Time

Child, Adolescent, and Family Psychiatry

Albert L. Sprinkle, III, M.D. **Robert L. Geist, Ph.D.**
J. Danny Dutton, Ph.D., LPC-S **Stacey Jackson, LCSW, PIP**
Laura A. Graham, CRNP, PMHNP-BC **Mary Ann Nichols, LPC**

190 Lime Quarry Rd, Suite 115, Madison, AL 35758 **Phone:** 256-270-9483 **FAX:** 256-325-0340

CONFIDENTIALITY STATEMENT

For Patients, Visitors, Guest

As a patient, visitor, or guest at Valley Psychiatric Associates, I understand that Federal Regulations on Confidentiality require that I not reveal the identity of any person I may see or the identity of any person's record that I may see while at the office.

I understand that any disclosure of patient information, including the person's presence in treatment, or any description of any person, without specific written consent from that person may be interpreted as a Federal Criminal Offense.

I agree to maintain patient's confidentiality.

_____ _____
Printed Name **Date**

_____ _____
Signature **Witness**

Valley Psychiatric Associates, P.C.

PATIENT CONTRACT

Our staff attempts to provide the best services possible. All services are directed by a psychiatrist, board certified in child and adolescent psychiatry as well as general adult psychiatry. Our staff works hard to maintain professional skills through regular continuing education courses. However, we can only provide the best possible service when we work together with you. In order to help you understand your role, this contract sets out office guidelines.

Co-pays and deductibles are due at the time of service. You will be responsible for whatever the insurance does not pay.

****Please note** whomever brings a child in to be seen is responsible for payment at the time of service. It is the custodial parent's responsibility to arrange reimbursement from a non-custodial parent. The legal guardian must accompany a minor child.** Please do not bring younger siblings to appointments, if possible.

Insurance companies vary their requirements. It is **your** responsibility to check with the insurance company regarding benefits. If you need assistance dealing with your insurance company, this office will be available.

Outstanding accounts that cannot be collected through this office will be turned over to a collection agency after 90 days delinquency. **ALL COST** incurred to collect debt will be added to the account balance, including attorney fees.

Our providers see patients for treatment purposes only. Requests for testimony in any court require a separate VPA Forensic Contract.

You will be charged for missed appointments or appointments cancelled less than 24 hours before your appointment. This charge is not reimbursed by any insurance company. Treatment is only successful when you attend all appointments. If an emergency occurs call the office as soon as possible. Please do not come if you are sick (fever greater than 100, vomiting more than once, persistent diarrhea) as this simply spreads it to everyone, including us. Call as soon as you can when you are sick so that we can reschedule.

If **Madison City Schools** are closed for bad weather, then our office will close. **IF SCHOOLS ARE ONLY DELAYED DUE TO WEATHER, APPOINTMENTS WILL BE KEPT AS SCHEDULED.**

You are responsible for your medications. Bring the bottles when you see the physician. If you need a refill you must give 5 working days notice before you are out of medication. There is a $10.00 charge for any prescription requested with less than 5 days notice.

There will be charges **up to $45.00 for forms** to be filled out by this office. Example: FMLA or student accommodation forms, or Prior Authorizations.

Patients receiving medications from VPA medical staff are expected to be actively involved with a VPA therapist. Receiving scheduled prescription medications from a VPA provider and another provider will result in your case being closed.

Missing any three (3) appointments (physician, individual, family, or group) will be demonstration of your unwillingness to cooperate with treatment and grounds for immediate termination of services through this office. You will be notified by mail. There will be a **$45.00** fee for **each** missed appointment prior to termination.

It is your responsibility to let us know if there is a problem with the services you receive. You should discuss any problems with the office manager, therapist, or physician. We can't fix what we don't know.

In the event of an emergency outside of office hours call 911 or go to the nearest emergency room.

I have read and understand this contract. I agree to abide this contract while receiving services.

_____ _____

Date Patient's Name (print)

_____ _____

Witness Signature of Patient or Guardian

_____

Print Name of Guardian

Adult Patient History

We would like to know about you and would appreciate you taking a few minutes to answer the following questions.

Medical History

1. List any medical problems, past or present _____

   _____.
2. List any allergies _____.
3. List any current medications _____.
4. What problems bring you to our office? _____

   _____.
5. Who referred you to our office? _____.
6. Who is your primary care physician? _____.
7. Any current or past alcohol, drug or tobacco use? _____

   _____.

Family Life

1. Have you ever been treated by a psychiatrist, therapist, etc.? If you have had any testing done please bring a copy to the office. _____

   _____
2. Has anything unusual ever happened to you? Please explain _____

   _____
3. Has anyone in your family (your parents, relatives) been treated for anxiety, depression, etc.?

   _____
4. What are the current stressors in your life? _____
5. Highest level of education _____
6. Any religious preference? _____
7. Any military history? _____
8. Leisure activities you enjoy _____