Valley Psychiatric Associates, P.C.

CHILD PATIENT INFORMATION

Name _____ DOB _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Referred by _____

Sex: M F Social Security Number _____

Mother's Name _____ DOB _____ SSN _____

Father's Name _____ DOB _____ SSN _____

FOR MINORS PLEASE INDICATE THE PARENT TO WHOM BILLS SHOULD BE ADDRESSED

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 _____ Referred by _____

Name and Address of Non-Custodial Parent (if any) _____

Address _____ City _____ State _____ Zip _____ Phone _____

DOB _____ SS# _____ Place of Employment _____

INSURANCE

Primary Insurance Company _____ Subscriber Employer _____

Contract Number _____ Group Number _____

Subscriber Name _____ DOB _____ SSN _____

Subscriber Address _____ City _____ State _____ Zip _____

****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.**

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.*

PHARMACY INFORMATION & AUTHORIZATION

I hereby authorize Valley Psychiatric Associates to contact my pharmacy for any reason relating to my treatment, including but not limited to, calling in prescription refills, cancelling old prescriptions on file, confirming refill schedule, and processing prior authorizations.

Pharmacy Name

_____

Pharmacy Phone Number

(_____) _____

Pharmacy Fax Number

(_____) _____

Pharmacy Address

_____

_____

_____

I have read the above authorization and understand the same.

_____ _____

Signature Date

_____ _____

Witness Date

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

EMAIL AUTHORIZATION

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

I further acknowledge and understand that the security of my email inbox is the responsibility of myself, my internet service provider, and my email provider, not Valley Psychiatric Associates.

Email: _____ @ _____. _____

I have read the above authorization and understand the same.

_____ _____

Signature Date

_____ _____

Witness Date

*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.

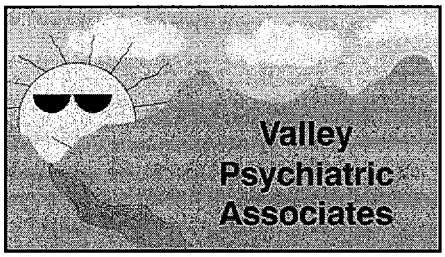
I have read the above authorization and understand the same.

_____ _____

Signature Date

_____ _____

Witness Date



Child, Adolescent, and Family Psychiatry

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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. 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.

Effective February 1st 2022

In the event of an emergency, call 911 or go to the nearest emergency room.

****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 to each appointment with a physician or nurse practitioner.**

Co-pays and deductibles are due at the time of service. You will be responsible for whatever the insurance does not pay. Insurance companies vary their requirements. **If you have a deductible policy**, our office will collect **$60 per session** until we know what exact amount insurance is requiring. *Once we hear from your insurance company, we will collect the exact amount for each session.*

If an outstanding balance has not been paid within **90 days**, this office will suspend treatment until full payment is received. In some cases, payment plans may be available. If a balance is over **120 days**, this office will terminate treatment due to the unpaid balance.

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. Missed or same day cancellation appointments with a **medicine provider will be $45**, which will need to be paid before rescheduling. Missed or same day cancellation appointments with a **therapist will be $70,** which will also need to be paid before rescheduling.

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. Please bring the bottles when you see the physician or nurse practitioner**. If you need a refill, you must give 7 working days' notice before you are out of medication.** *If one of your medications is changed or adjusted, you must be seen by your medicine provider within 4-6 weeks to receive any more refills.*

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 strongly encouraged to be 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.

I have read and understand this contract, and I agree to abide by this contract.

_____ Date

_____ Patient's Name (print)

_____ Witness

_____ Signature of Patient or Guardian

_____ Print Name of Guardian

Valley Psychiatric Associates, P.C.

We want to learn things about your child's life. The following questions will aid us in gathering information and allow you to look up important events and remember important details you may wish to discuss with the doctor.

EARLY DEVELOPMENT

Were there any problems with your pregnancy with this child? _____

How much did either parent smoke, drink alcohol, or use drugs before, during, or after pregnancy?

MOTHER _____ FATHER _____

Was your child born on time? _____ Were there any problems at the time of delivery? _____

_____ Jaundice (yellow skin) _____ Need I.V. or Antibiotics _____ Breathing Problems

_____ Need Special Care Nursery _____ Other _____

As an infant, was your child ____ Sickly ____ Colicky ____ Poor Sleeper ____ Feeding Problems ____ Easy Baby to Care For

At what age did your baby? _____ Sit Up _____ Walk _____ Toilet Trained

At what age did you regularly leave your child with another caretaker? _____

EDUCATION

What was your child's first school experience? _____ Head Start _____ Pre-School _____ Kindergarten _____ Other

What grade is your child in? _____ Any problems at school? _____

FAMILY LIFE

How many people live in your house? _____ How many houses has your child lived in? _____

Has your child ever been treated by a psychiatrist, psychologist, therapist or counselor? _____ (If your child has been tested, please bring a copy to your appointment)

Has anything unusual ever happened to your child? (If so, please explain)_____

Has anyone in the extended family ever been treated by a psychiatrist, psychologist, or a doctor for nerves? _____

Name and DOB of any siblings_____

MEDICAL HISTORY

Who is your child's pediatrician? _____

List any medical problems: _____

List allergies: _____

List any medications the patient is currently taking: _____

What problems bring you to our office? _____

_____

Who referred you to our office? _____