Comprehensive MedPsych Systems, Inc.

Pediatric Registration Form

Child's Name: _____Date: ____/____/____

Address: _____ City/State _____ Zip_____

Phone: (home): _____-_____-_____ (work): _____-_____-_____ (cell): _____-_____-____

Date of Birth: ___/___/___ Age: ___ Sex: Male/Female Child's Social Security (required): ____-____-____

1st Parent/Legal Guardian Name: _____
Address: (if different) _____
Date of Birth: _____/_____/_____ Age: _____ Social Security (required): _____/_____/_____

2nd Parent/Legal Guardian Name: _____
Address: (if different) _____
Date of Birth: _____/_____/_____ Age: _____ Social Security (required): _____/_____/_____

I have the legal authority to make medical decisions for this child (sign below)

_____ _____ _____ _____
Signature ***Print Name*** ***Relationship*** ***Date***

CONSENT FOR MENTAL HEALTH SERVICES

I hereby consent to engage in Diagnostic and/or Therapeutic Mental Health Services provided by one or more staff members of Comprehensive MedPsych Systems, Inc.

PATIENT RIGHTS & COMPLAINT PROCESS

I understand that I have a right to refuse treatment at any time. Unless otherwise agreed to in writing in such cases where HIPAA does not apply, I have a right to review my records, diagnosis, and treatment plan. I understand that if I feel that my rights have been violated, it is my right to file a complaint with the State of Florida (see posted Consumer Assistance Notice).

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE TO PRIVACY PRACTICES

I was provided a copy of the Notice of Privacy Practices for review from either the CMPS website or at the office.

Please sign and print your name and date on this acknowledgement form, that you have read and understand the above policies.

_____ _____ ____/____/____
Print Patient Name ***Signature*** of Patient/Guardian Date

CONTACT INFORMATION

Call Preference:

What phone number should we call? _____-_____-_____ ☐ my home
_____-_____-_____ ☐ my work
_____-_____-_____ ☐ my cell

If unable to reach me:

☐ you may leave a detailed message
☐ please leave a message asking me to return your call
☐ _____

Emergency Contact:

In the event that we need to reach someone on your behalf please provide an emergency contact.

Name: _____

Relationship: _____ Phone #: _____

Appointment Reminders:

As a courtesy we can send you appointment reminders via email, text, or phone. Please choose which option you prefer.

☐ e-mail address _____
☐ text – cell phone # _____
☐ phone message – cell or home phone # _____

I authorize CMPS to send me appointment reminders.

_____ _____ _____/_____/_____
Print Patient Name ***Signature*** of Patient/Guardian Date

RELEASE OF CLINICAL INFORMATION

Information cannot be released without consent except under the following circumstances which may require by law, reporting to the State of Florida or otherwise releasing information to another party without consent:

1. If there is imminent danger of self-neglect or self-harm or imminent danger to another individual.
2. If there is suspicion of child abuse or neglect.
3. If there is suspicion of elder abuse or neglect.
4. If there is suspicion of abuse or neglect of a disabled individual.
5. If there is suspicion of an inappropriate sexual relationship with a healthcare provider.
6. If legal action is brought involving mental health damages.
7. If there is a court order signed by a judge.
8. If evaluation or treatment is provided with forensic/legal or Workman's Compensation involvement where the client is another individual or agency with whom information may be shared without your consent.

For the purposes of continuation of my medical care I give permission to release my medical records to the following (please check boxes):

☐ **Primary Care Physician** ☐ **Referring Provider** ☐ **Other Clinician:** _____

Initial: _____

*** NO SHOW AND CANCELLATION POLICY ***

THE FEE for a no-show or cancellation less than 5 business days in advance is $100.00 for a counseling, therapy, or psychiatry appointment; and $300.00 for psychological or neuropsychological testing.

The fee will be waived if you are able to reschedule the appointment within the same week if your provider has availability. The fee may be waived upon discussion with your provider or CMPS administrative staff.

You have made a commitment for that day and time and it cannot be easily filled even with several days' notice. If there is a serious illness or emergency event that would prevent you from coming to your appointment, you must contact our office as soon as possible and speak directly to your provider or the local Office Manager. Simply leaving a message on the phone canceling your appointment will not relieve you of your financial responsibility. Note that insurance companies cannot be legally billed for a no-show or cancellation.

I certify that I have read and understand the above and I accept all specified terms and fees therein, and have received information on patient rights including the process for initiation, review, and resolution of complaints.

Initial: _____

CONTACT WITH CMPS STAFF OUTSIDE NORMAL BUSINESS HOURS (9:00am-5:00pm)

I understand that:

- Comprehensive MedPsych Systems (CMPS) is a behavioral health private practice; we are not a community mental health center or a crisis center. **CMPS does not provide crisis services after normal business hours.**
- I understand that if a medical or mental health emergency arises, I am to call 911 or go to the closest Emergency Department.
- I understand that leaving a phone message, text message, social media message, or e-mail message with my mental health provider is not an appropriate manner in which to communicate clinical information and especially crisis or emergency information. These modes of communication are not monitored on a regular basis and may not be received; such messages may not be responded to by your provider.
- While CMPS does have an after-hours Answering Service for after business hours messages and an administrator is on-call to help direct you for emergency situations, your specific provider may not be available to speak to you. If the on-call CMPS administrator does not reach you, then you must call 911 or go to the closest Emergency Department. If you leave a non-emergency message with the Answering Service, your provider or other CMPS office staff will contact you the next business day.
- **Medication refills are NOT considered an emergency or crisis circumstance**. You are strongly encouraged to monitor your medication usage and make sure you make arrangements with CMPS office staff during regular business hours in a responsible manner with enough notice to allow our staff to facilitate refills which may require 24 to 48 hours (and sometime longer depending upon pharmacy, insurance plan, medication availability, authorization, or other factors) so you do not run out of medication.
- **Appointment scheduling (*including cancellation and late arrivals*) is not considered an emergency or crisis circumstance**. Please leave a message and your provider or CMPS office staff will contact you the next business day. ***Leaving a message for your provider or with the Answering Service for late arrival or cancellation does not release you from your financial late fee obligations (i.e., we require 5 business day notice).***

Please sign and print your name and date on this acknowledgement form, that you have read and understand the above policies.

_____ _____ ____/____/____

Print Patient Name ***Signature*** of Patient/Guardian Date

FINANCIAL AGREEMENT

IF THE INSURED IS ***NOT*** THE PATIENT PLEASE COMPLETE THIS INFORMATION. DO NOT COMPLETE IF WE WILL NOT BE BILLING YOUR INSURANCE COMPANY

Insured: _____ DOB: _____
Employer (if group policy): _____
Relationship to Patient: Spouse_____ Child_____ Other_____ (if other, please explain below)
_____
_____
_____

INSURANCE PRE-CERTIFICATION

I hereby expressly understand that I personally am responsible for any required notification to my insurance company to obtain authorization before service is rendered. ***Initial***: _____.

FINANCIAL AGREEMENT

I understand that I am responsible for the charges not covered by insurance which are allowable by contract and by law. I hereby guarantee prompt payment of all charges incurred for services rendered not covered by insurance carriers or others.

I agree to maintain a current credit card on file at CMPS and that my credit card can be charged for any outstanding balance as per my insurance EOB for deductible and/or co-pay or co-insurance.

If there is an account balance due that is unable to be charged to the card on file, the bill may be turned over to an attorney or a collection agency, and the undersigned shall be liable for attorney's fees and/or collection agency's fees and expenses. Any patients having an outstanding balance that is referred to a collection agency will not be able to make an appointment until the balance is paid in full. ***Initial***: _____.

ASSIGNMENT OF BENEFITS

If I am entitled to mental health benefits arising out of any insurance policy or from any person or organization who is or may become liable to me to provide such benefits, I hereby assign and authorize payment of such benefits for mental health services to which I am entitled to Comprehensive MedPsych Systems, Inc. for services rendered to me.

If applicable, I request that payment of Medicare benefits for psychological services be made on my behalf and assign them to Comprehensive MedPsych Systems, Inc. and authorize submission of the necessary claims for payment. I authorize any holder of medical, mental health, and/or any financial information about me to release to the Health Care Financing Administration, or Medicare intermediaries, or Medicare Carriers any information needed for proper reimbursement. ***Initial***: ____.

RELEASE OF INFORMATION FOR PAYMENT

I expressly authorize any agent of Comprehensive MedPsych Systems, Inc. to release all or part of my mental health record by telephone, by facsimile transmission, by e-mail, or in writing when required by law or government regulation, or as a condition for payment of charges for insurance carriers or other reimbursers or utilization review bodies. Comprehensive MedPsych Systems, Inc., its agents, servants, and employees are hereby released from any and all liability that may arise from the release of such information. ***Initial***: _____.

Please sign and print your name and date on this acknowledgement form, that you have read and understand the above policies.

_____ _____ _____/_____/_____
Print Patient Name ***Signature*** of Patient/Guardian Date