PATIENT REGISTRATION FORM

Today's Date:				
PATIENT INFORMATION				
Patient's last name:		First:		Middle Initial:
D.O.B:	Age:	SSN (required):	Sex:	Marital Status:
Address:				
City:		State:		Zip:
Home phone:		Work phone:		Cell phone:
Email Address:		Referred by:		
Other family members seen here? ☐ Yes ☐ No If yes, name:				
PARENT/LEGAL GUARDIANS (for patients who are minors or have legal guardians)				
1st Parent/Legal Guardian name:				
Address (if different):				
D.O.B:	Age:	SSN (required):		
2nd Parent/Legal Guardian name:				
Address (if different):				
D.O.B:	Age:	SSN (required):		
IF THE INSURED IS NOT THE PATIENT (please complete if applicable)				
*Do NOT complete if we will NOT be billing your insurance company:				
Insured:		D.O.B:		
Employer (if group policy):				
Relationship to patient: ☐ Spouse ☐ Child ☐ Other (if other, explain below)				

_____

_____

REMINDER CALLS

We offer an automated reminder that will contact you two business days ahead of time to remind you of your appointment. Please choose one of the following options:

☐ Yes, I want CMPS to send me appointment reminders
- ☐ Phone call with automated message
- ☐ Text message to your cell phone
- ☐ Email message

☐ No, I do not want CMPS to send me appointment reminders

PATIENT REGISTRATION FORM (continued)

COORDINATION OF CARE			
It is important for your healthcare providers to work together in coordinating your care. Please complete information below and indicate your approval.			
Primary Care Physician:		Phone:	
Address:	City:	State:	Zip:
May we contact your Physician? ☐ Yes ☐ No ☐ I don't have a Physician			
Psychiatrist/Therapist:		Phone:	
Address:	City:	State:	Zip:
May we contact your Psychiatrist/Therapist? ☐ Yes ☐ No ☐ I don't have a Psychiatrist/Therapist			
IN CASE OF EMERGENCY			
Emergency contact name:		Relationship:	
Address:	City:	State:	Zip:
Home phone:	Work phone:	Cell phone:	
AUTHORIZATION TO RELEASE LIMITED INFORMATION			
If there is anyone whom you give permission to release limited information on your account, please list these names below (including parents/legal guardians if patient is under 18) and specify what information they may access. No other information other than what you list will be released. NOTE: This is not a full medical records access request. If no one else is granted permission to access your account, please state "NONE."			
Name:	Relationship:	Phone number:	
What info may be released? ☐Appointment Details ☐Financial/Pay Bill ☐ Pick up Prescription			
Name:	Relationship:	Phone number:	
What info may be released? ☐Appointment Details ☐Financial/Pay Bill ☐ Pick up Prescription			
Name:	Relationship:	Phone number:	
What info may be released? ☐Appointment Details ☐Financial/Pay Bill ☐ Pick up Prescription			
The above information is true to the best of my knowledge. I authorize you to release any information required to process my claims. I understand that I am financially responsible for any balance not paid by insurance. I have received a copy of the Provider and Patient Services Agreement and agree to its terms.			
Signature of Patient/Guardian:		Date:	

AUTHORIZATION FOR TREATMENT, PAYMENT & HEALTHCARE OPERATIONS

By my signature below, and my presence at CMPS, I hereby authorize CMPS to provide mental health care.
I authorize Comprehensive MedPsych Systems, Inc. to release to my insurance company, managed care organizations, state agency/agencies, Health Care Financing Administration, Third Party Administration, and/or Workers' Compensation or its agents any information needed to process my claims and/or determine benefits payable for related services. Initial: _____

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. Initial: _____

If applicable, I request that payment of Medicare benefits for mental health 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 Carries any information needed for proper reimbursement. Initial: _____

I understand that Comprehensive MedPsych Systems, Inc. participates and/or has contracted agreements with selected insurance plans/third party payers. I understand that unless otherwise restricted by a contractual agreement with such plans/third party payers, the entirety of the charges incurred that I agree to will be transferred to the guarantor's responsibility as per the EOB or if the payment is not received from insurance within 60 days. I understand that I will be bound by any conditions of this agreement regarding guarantor/patient responsible charges. I understand that failure to meet my financial responsibilities in a timely manner may result in my account being turned over to a collection agency. I understand that I am responsible for any collection fees, attorneys' fees, and/or court fees that may be involved. Initial: _____

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 and/or missed appointment fee. Initial: _____

I understand that I must provide Comprehensive MedPsych Systems, Inc. no less than 5 business days notice to cancel an appointment. Same day appointment cancellations are subject to a charge that shall be billed directly to me, and payment of any missed appointment charge will be my sole responsibility. Initial: _____

I understand that all patient responsible charges are due to prior services rendered. Initial: _____

I agree to the above conditions.

_____ _____

Signature of Patient/Guardian Date

LATE CANCELLATION/NO SHOW APPOINTMENT POLICY

Mental Health care requires the collaboration effort of both you and your clinician. When you do not come to your scheduled appointment or cancel your appointment without the required 5 business day notice, not only do you miss an opportunity for treatment, but you also deny someone else the opportunity as well.

We offer a courtesy reminder via text, email, or voice message to remind you of your appointment, however, you are ultimately responsible for keeping your appointments. **Consequently, late cancellations and no show appointments will be charged a $100 fee for psychiatry and psychotherapy appointments, and $300 for psychological or neuropsychological testing appointments. Payment will be expected on or before your next scheduled appointment.**

Insurance companies do not pay for either late cancellations or missed appointments.

THE RESPONSIBILITY IS YOURS.

I HAVE READ AND AGREE TO ABIDE WITH THIS POLICY.

_____ _____

Signature of Patient/Guardian Date

ACKNOWLEDGMENT OF RECEIPT OF PATIENT NOTIFICATION OF PRIVACY PRACTICES

I, _____ , have been presented with a copy or given information regarding access to a copy of Comprehensive MedPsych Systems' Patient Notification of Privacy Practices, detailing how my information may be used and disclosed as permitted under federal and state law, and I understand the contents of the notification. By law, CMPS is required to obtain your signature indicating you have received this document. Your signature below does not surrender any rights or confidentiality. Any updates to this policy will be posted on our website and in our lobby for review.

_____ _____

Signature of Patient/Guardian Date