

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? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name:					
PARENT/LEGAL GUARDIANS (for patients who are minors or have legal guardians)					
1 st Parent/Legal Guardian name:					
Address (if different):					
D.O.B:	Age:	SSN (required):			
2 nd 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: <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other (if other, explain below)					

COORDINATION OF CARE / RELEASE OF RECORDS					
It is important for your healthcare providers to work together in coordinating your care. Please complete the information below and indicate your approval.					
Primary Care Physician:			Phone:	Fax:	
Psychiatrist/Therapist:			Phone:	Fax:	
For the purposes of continuation of my medical care I give permission for CMPS to contact and/or release copies of my visit notes to the following when requested. Initial: _____					
<input type="checkbox"/> Primary Care Physician <input type="checkbox"/> Referring Provider <input type="checkbox"/> Other Clinician: _____ <input type="checkbox"/> No information may be released NOTE: This is not a full medical records access request. That would still require a separate Release of Information (available on our website or at the front desk) to be signed and returned to the Medical Records Department.					

PATIENT REGISTRATION FORM (continued)

Patient's Name _____

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

IN CASE OF EMERGENCY

Emergency contact name:		Relationship:	
Address:	City:	State:	Zip:
Home phone:	Work phone:	Cell phone:	

RELEASE OF LIMITED INFORMATION

I give CMPS authorization to leave me a voice message regarding:

- Appointment Details
 Financial/Pay Bill
 Prescriptions

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? <input type="checkbox"/> Appointment Details <input type="checkbox"/> Financial/Pay Bill <input type="checkbox"/> Pick up Prescription		
Name:	Relationship:	Phone number:
What info may be released? <input type="checkbox"/> Appointment Details <input type="checkbox"/> Financial/Pay Bill <input type="checkbox"/> 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.

Signature of Patient/Guardian:	Date:
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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 Carriers 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

AUDIO OR VIDEO RECORDING OF ANY SESSION IS FORBIDDEN

According to Florida law and under penalty of Florida law, I agree that neither I nor any other participant in my session(s) will record any audio or video portion of my session without written mutual consent from myself and my provider (and any other participant as applicable). No matter which state I or my provider are in during my treatment session(s), if I or any participant in my session do record any audio or video information during my treatment session(s) without written mutual consent, the session will immediately be terminated (with my obligation to pay the full fee for the session), all future treatment sessions of any kind will be canceled/terminated, and I will be permanently discharged from my provider and all providers in the CMPS company.

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