Lafayette Psychiatric Services- ADULT Patient Registration Date:_____

Name:_____ Sex: M__ F__ Other:_____
First Middle Last

Email address:_____

Phone #'s: Home_____ Work_____ Cell_____

Best number to reach for reminders:_____

Address:_____ City:_____ State:____ Zip:_____

Birthdate:_____ Social Sec. #:_____ Marital status: Married__ Single__ Divorced__

Employer Information

Employer Name:_____ Address:_____Phone:_____

Spouse's name:_____ Spouse's Phone:_____ Spouse SSN:_____

Spouse's employer:_____
Employer's name address phone

Emergency contact: _____ *Relationship to patient:*_____

*Address:*_____

Phone #'s: Home _____ *Work:* _____ *Cell:*_____

Insurance Information:

Primary Insurance:_____ Subscriber #:_____

Group #:_____

Subscriber's name:_____ Relationship to patient:_____

Secondary Insurance:_____

REQUIRED: Subscriber's date of birth:_____ Subscriber's gender: M__ F__ Other_____

Person responsible for bill:

Name:_____ Address:_____

Soc sec #:_____ Phone #'s Home:_____ Work:_____ Cell:_____

LAFAYETTE PSYCHATRIC SERVICES
160 Kingsley Lane, Suite 204
Norfolk, Va. 23505
Phone (757) 489-4700 Fax (757) 955-8060

Patient name:_____ Birth date: _____
Today's Date:_____

To: Primary Care Physician: _____
Address:_____
_____
Phone #:_____ Fax:_____

Dear Dr.:_____
In an effort to coordinate care, I am informing you that your patient (named above) was seen by me on _____for (diagnosis code)_____**This is NOT a request for records, simply a notice that the patient has been seen (in the interest of coordination of care). Please contact us if you desire further information.**

Current recommendations for the type and setting of treatment include:

( ) Individual Therapy
( ) Family Therapy
( ) Inpatient treatment
(X) Medication therapy (listed below):
_____
(X) Outpatient
( ) Intensive outpatient program
( ) Partial Hospital Program
( ) Other:_____

If you need further information please contact me at (757) 489-4700

Sincerely
( ) Huma Hyder, MD ( ) Paul Callis, PA

Release for coordination of treatment with primary care physician

For the purpose of coordinating care, my behavioral health care practitioner may wish to release pertinent information about my current treatment to my primary care physician. I hereby authorize the use or disclosure of my individually identifiable health information. This release shall be valid until sixty (60) days after my last date of treatment or until the time I revoke this release, which can be done at any time.

(**Check one**) I do ( ) / I do not ( ) give permission to the practitioner specified above to release information about my current treatment to my primary care physician.

Patient Signature (or Guardian, if patient a minor): _____

Witness Signature: _____

OFFICE POLICIES AND CONSENT

CANCELLATIONS MUST BE MADE ATLE4ST 24 HOURS IN ADVANCE. This will allow other patients to be seen. If Cancellations are not made at least 24 hours in advance, you will be charged $25 for your missed appointment.

Prescription renewals are contingent on keeping scheduled appointments. Prescriptions will not be refilled after hours or on weekends. Schedule 2 and Schedule 4 controlled substances will NOT be refilled without an appointment. Early refills will not be given.

The Patient or Responsible Party shall pay any outstanding balance which is not covered by the insurance (e.g., deductible, co-payments, denied claims). The Patient or Responsible Party may receive a statement whenever there is an outstanding balance. **The Patient or Responsible Party- not the insurance company- is ultimately responsible for the payment for the services rendered (this includes Medicaid patients). Medication may not be refilled if there is a balance above $50.00 on your account.**

We make every effort to protect your confidentiality regarding treatment & we are committed to protecting the privacy of your medical records. We may use information you give us to obtain payment for services & for administrative purposes. We may disclose your information without your consent under certain circumstances such as emergencies or as required by law. Under any other circumstances, we will request your written authorization to disclose information. A fee of $20.00 will be charged for releasing medical records to a new provider. All forms except SSD will be filled for a fee of $25.00.

I _____ (*print patient's name, if minor print parent's name*) acknowledge that I have read and understand the information regarding my privacy rights while receiving services from Lafayette Psychiatric Services.

____ (*Initial)* I acknowledge that the indications, risks, potential benefits, and possible side effects/adverse reactions of therapy with controlled substance and neuroleptics have been explained. I further acknowledge I have had the opportunity to ask questions, and all questions have been answered to my satisfaction.

____ (*Initial)* I agree that LPS may call, or send a text message to, phone numbers provided by me to confirm appointments or leave reminder messages regarding appointments.

____ (*Initial)* I agree that LPS may send me emails to the email address provided to co Irm appointments, leave reminder emails about appointments & to send statements regarding cha es & payment for treatment.

____ (*Initial)* I also consent for Lafayette Psychiatric Services to access my medical & medicatiön history from other medical providers & the Prescription Monitoring Program database.

____ (*Initial)* It is my responsibility to understand my insurance coverage & benefits including precertification, referrals & authorization requirements. (We will assist you to ensure that all plan requirements are met, However, if there is a lapse in your coverage you, the patient, will be responsible for all outstanding balances. **This includes Medicaid patients**).

Lafayette Psychiatric Services
Consent for Treatment, Statement of Fees & Method Form
Name of Patient:_____ Date:_____
Name of Responsible Party: _____ SSN: _____

This form is utilized to establish a clear understanding regarding the details of your treatment as well as your financial account with our Practice. Please read it entirely and ask any questions you may have. **YOUR SIGNATURE IS AN ACKNOWLEDGMENT OF YOUR UNDERSTANDING & AGREEMENT WITH PROVISIONS.**

I, _____ hereby authorize Lafayette. Psychiatric Services (LPS) and/or its designees to provide medical treatment, counseling/psychotherapy, release information pertaining to treatment for insurance purposes, & to receive direct insurance payments for professional treatment otherwise payable to me for services rendered**. I understand that I am financially responsible for payment for all services at the time they are rendered unless other arrangements have been made in writing.**

____ (*Initial)* I agree that LPS may call, or send a text message to, phone numbers provided by me to confirm appointments or leave reminder messages regarding appointments.

____ (*Initial)* I agree that LPS may send me emails to the email address provided by me to confirm appointments, leave reminder emails about appointments & to send statements regarding charges & payment for treatment.

I also consent for Lafayette Psychiatric Services to access my medical & medication history from other medical providers & the Prescription Monitoring Program database.

It is my responsibility to understand my insurance coverage & benefits including precertification, referrals & authorization requirements. (We will assist you to ensure that all plan requirements are met. However, if there is a lapse in your coverage you, the patient, will be responsible for all outstanding balances. **This includes Medicaid patients**).

I agree to be responsible for payment in full of all charges for professional services which have been rendered to the above-mentioned Patient by Lafayette Psychiatric Services. I also understand & agree to the following provisions regarding the fee & method of payment:

If desired, Lafayette Psychiatric Services shall file insurance claims on behalf of the Patient for services rendered. Insurance payment shall be made directly to the Practice. Should payment be made to the Patient or Responsible Party by the insurance carrier, the Responsible Party agrees to promptly forward payment to the Practice.

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Lafayette Psychiatric Services for any service furnished me by any provider in that group. I authorize any holder of medical information about me to release to Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services:

The Patient or Responsible Party will supply to the Practice any insurance forms that may be necessary to expedite the filing process on a monthly basis.

The Patient or Responsible Party shall pay the estimated "co-insurance payment" **AT THE TIME OF EACH VISIT**. This is the amount which is ESTIMATED as not being covered by the Patient's insurance.

The Patient or Responsible Patty shall pay any outstanding balance which is not covered by the insurance (e.g., deductible, co-payments, denied claims). The Patient or Responsible Party may receive a statement whenever there is an outstanding balance. **The Patient or Responsible Party- not the insurance company- is ultimately responsible for the payment for the services rendered (this includes Medicaid patients).**

It is understood that the usual and customary collection procedures may be initiated should the account become delinquent. This may include the referral of the account to a collection agency or attorney. The Patient and the Responsible Party authorize Lafayette Psychiatric Services to inquire into open or paid credit & the Responsible Party agrees to be responsible for all costs & expenses of collection, including but not limited to attorney's fees and/or collection agency fees of 33 1/3 % of the balance due.

By signing below, each of the Patient & the Responsible Party makes the following statement:
I UNDERSTAND THAT IF I DO NOT PAY LAFAYETTE PSYCHATRIC SERVICES FOR SERVICES RENDERED, THAT LAFAYETTE PSYCHIATRIC SERVICES MAY TURN MY ACCOUNT OVER TO AN ATTORNEY OR A COLLECTION AGENCY FOR COLLECTION. I ALSO UNDERSTAND THAT INFORMATION REGARDNG MY DELINQUENT ACCOUNT MAY BE REPORTED TO A CREDIT REPORTNG-AGENCY. I ALSO UNDERSTAND THAT THE TURNING OVER OF MY DELINQUENT ACCOUNT TO AN ATTORNEY OR COLLECTION AGENCY FOR COLLECTION, & ANY REPORTS OR INQUIRIES TO A CREDIT REPORTNG AGENCY, MAY DISCLOSE THAT THE PATIENT IS A PATENT OF LAFAYETTE PSYCHIATRIC SERVICES & I HEREBY CONSENT TO ANY SUCH DISCLOSURE.

I have been provided with a copy of this agreement.

It is understood & agreed that a charge will be placed on the account if an appointment is missed or canceled without 24-hour notice.

Additional details or considerations regarding the method of payment may be outlined below.

_____	_____	_____	_____
Patient's signature	Date	Responsible Party	Date