PATIENT INFORMATION FORM - PSYCHIATRIST

DATE: ____________________________

PATIENT NAME: ____CHILD / ADULT (please circle)

ADDRESS: ____ CITY: _____________________________

STATE: ________________ ZIP: ______________ PATIENT DATE OF BIRTH: ______________________

HOME#: _________________________________ CELL#: __________________________________

EMAIL: _____________________________________ PATIENT MARITAL STATUS: ________________

REFERRING PHYSICIAN/PERSON: ____

Was patient or family previously seen at Short Hills Associates? YES_________ NO____________

PERSON RESPONSIBLE FOR PAYMENT: (If same as above disregard)

NAME: ____

ADDRESS: ____ CITY: _____________________________

STATE: _______________ ZIP: ______________ EMAIL: _____________________________________

HOME#: _________________________________ CELL#: ______________________________________

NOTIFY PERSON IN CASE OF EMERGENCY:

NAME: ____ RELATIONSHIP: ___________________

PHONE(S):______________________________ ADDRESS: ____

PHARMACY INFORMATION:

NAME: _____________________________PHONE:_______________________________

ADDRESS: ____

ADDITIONAL PHARMACY (MAIL-ORDER) ____

EMPLOYMENT DATA:
(If the patient is a child, please give information pertaining to the insurance policyholder)

NAME OF COMPANY: ______________________________ ADDRESS: ___________________________

OCCUPATION: _______________________________________ PHONE: ___________________________

Do we have permission to contact you at your place of employment? _____________

If the patient is a child, please provide the following information:

SCHOOL/DISTRICT: ____GRADE:_____

PEDIATRICIAN: ____ PHONE: ______________________

INSURANCE INFORMATION:
Please be aware that we are only contracted with Aetna insurance company and will be filing insurance claims for you. All other insurance is considered Out of Network and we will not be filing claims.

Out of Network Rates:
Adult Evaluation: $400.00 Child Evaluation $600.00 Medication Management/Therapy $275.00

INSURANCE COMPANY: ____

NAME OF POLICYHOLDER: ____

RELATIONSHIP TO PATIENT: (please circle) SELF MOTHER FATHER SPOUSE OTHER _______

POLICYHOLDER DATE OF BIRTH: _______________________________

INSURED'S EMPLOYER: ____

POLICY#:_______________________________________ GROUP#:_______________________________

HAVE YOU MET YOUR DEDUCTIBLE FOR THIS YEAR? YES ______ NO ______

I authorize release of information to my insurance companies. I understand that I am responsible for my bill and authorize payment directly to my doctor. I authorize this practice and or its agents to act on my behalf to help me secure payment from my insurance companies. It is my responsibility to inform the office of my current insurance coverage and any change in coverage. If I am not in compliance with my plan procedures I will be responsible for the total balance of my bill.

____ ______________________________

SIGNATURE OF RESPONSIBLE PARTY **DATE**

TERMS AND CONDITIONS OF TREATMENT

Financial Responsibilities: Payment is expected at the time that services are rendered.

Aetna Insurance: This includes co-pay, co-insurance, and any deductible.

Out of Network: Full payment. Since we are not contracted with other insurance companies, a monthly receipt will be provided that you may submit to your insurance company for any reimbursement you may be eligible for.

Cancellation Policy: We require 24 hours notice for cancellation of appointments or you will be charged **$50** for the missed appointment.

Phone Calls: All calls should be directed to the front office x220 during business hours. Messages left after business hours will be returned the next business day.

Tele-Health: Appointments must be confirmed and Consent form must be signed and returned in order to receive the tele-health link via email.

Emergencies: In the event of an emergency when the office is closed, you may reach the clinician on call by dialing 973-900-1009. If you do not receive a timely response, call 911 or go to your nearest emergency room.

Charges and Fees: Please be aware that there may be additional fees for reports, letters, extensive phone contact, conferences with outside providers, etc.

Billing Questions: Please direct payment and billing questions to our staff at the front office.

Confidentiality: You have the right to privacy and confidentiality with your clinician. We abide by legal and ethical standards to maintain your confidentiality. Exceptions to this standard of privacy occur in the case of imminent risk or danger to oneself or others, child abuse or in the case of legal requirement. Please discuss this matter further with your clinician.

I HAVE READ AND I UNDERSTAND THE POLICIES OUTLINED ABOVE. I AM THE RESPONSIBLE PARTY FOR THE ABOVE NAMED PATIENT AND AGREE TO TREATMENT UNDER THESE CONDITIONS.

____ ______________________________

SIGNATURE OF RESPONSIBLE PARTY **DATE**

Relationship to Patient (please circle): SELF PARENT OTHER ________________

PLEASE KEEP THIS COPY FOR YOUR RECORDS

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Email: We cannot respond to any email regarding appointments, medications or other needs. You must call the front desk at x 220 with any requests.

Appointments: must be made and kept to comply with prescription refills. Please make follow up appointments as soon as possible. Appointment times, especially after school and evenings, book up quickly. Any change in medication must be discussed at an appointment with the Doctor and not over the phone.

Refills: All prescription refills must be called into our prescription line x 228. We require 48 hours in order to fill your request. We do not address refill requests from pharmacies as they are not deemed accurate. Do not rely on a text message from your pharmacy, call them to confirm that the prescription is ready. We will only call you back after you leave a message if there is a problem with the prescription.

Emergencies: In the event of an emergency when the office is closed, you may reach the clinician on call by dialing 973-900-1009. If you do not receive a timely response, call 911 or go to your nearest emergency room.

Other Charges and Fees: Please be aware that there may be additional fees for reports, letters, extensive phone contact, conferences with outside providers, etc.

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