Physicians
Department of Psychiatry and Behavioral Sciences
(405) 271-5251 • FAX (405) 271-5367

NEW PATIENT REGISTRATION FORM

PATIENT INFORMATION

First Name _____ **Middle Initial** _____ **Last Name** _____ ☐ **Male** ☐ **Female**

Date of Birth _____ **Social Security Number** _____ **Student** ☐Full-Time ☐Part-time ☐Not a student

Address _____ **LOT/APT NO.** _____ **Marital** ☐Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

City _____ **State** _____ **Zip** _____ **Employment** ☐ Full-Time ☐ Part-Time ☐ Unemployed ☐ Disabled ☐ Retired

Home Phone (____)_____ **Cell Phone (____)**_____ **Work Phone (____)**_____

Email _____ **Preferred communication** ☐ **Home** ☐ **Work** ☐ **Cell**

Primary Care Doctor: _____ **Referring Doctor:** _____

GUARANTOR/RESPONSIBLE PARTY INFORMATION

First Name _____ **Middle Initial** _____ **Last Name** _____ ☐ **Male** ☐ **Female**

Date of Birth _____ **Social Security Number** _____ **Student** ☐Full-Time ☐Part-time ☐Not a student

Address _____ **LOT/APT NO.** _____ **Marital** ☐Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

City _____ **State** _____ **Zip** _____ **Employment** ☐ Full-Time ☐ Part-Time ☐ Unemployed ☐ Disabled ☐ Retired

Home Phone (____)_____ **Cell Phone (____)**_____ **Work Phone (____)**_____

INSURANCE INFORMATION

PRIMARY INSURANCE NAME _____

POLICY ID NO. _____ **GROUP NO.** _____

NAME OF INSURED _____ ☐ **Female** ☐ **Male**

DATE OF BIRTH_____ **SOCIAL SECURITY NO.** _____

NAME OF EMPLOYER _____

SECONDARY INSURANCE NAME _____

POLICY ID NO. _____ **GROUP NO.** _____

NAME OF INSURED _____ ☐ **Female** ☐ **Male**

DATE OF BIRTH_____ **SOCIAL SECURITY NO.** _____

NAME OF EMPLOYER _____

EMERGENCY CONTACT INFORMATION

NAME _____ **RELATION** _____

HOME PHONE (____)_____ **CELL PHONE (____)**_____ **WORK PHONE (____)**_____

Psychiatry and Behavioral Sciences

PHYSICIAN TREATMENT INFORMATION

In order to provide you the most comprehensive care, our Physicians may incorporate therapy along with medication management as a part of your treatment. Please be aware that billing for therapy is separate from medication management and may be subject to different or additional copays, coinsurance and/or deductibles. Should you have concerns regarding this, please discuss with your physician.

CANCELLATION/NO SHOW POLICY

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

- If an appointment is not cancelled at least 24 hours in advance, you may be charged a fee as shown below. Your insurance company will not cover this fee.
    - $50 for appointments up to 60 minutes.
    - $50 per hour for appointments longer than 60 minutes.

- We understand that delays can happen; however, if you arrive 15 minutes past your scheduled appointment time, we may have to reschedule the appointment. If we have to reschedule, you may be charged for a missed appointment.

- If you miss more than three (3) appointments within a 12-month period, you may be discharged.

_____ _____/_____/_____

Signature Date

_____ _____/_____/_____

Printed Name Date of Birth

Department of Psychiatry and Behavioral Sciences

Worksheet for Completing Patient Demographic Questions

Information about race and ethnicity is an important part of your medical history. Each of us has diverse ancestries. This information helps us to proactively improve upon the quality of care and service we provide to all of our patients. If you have any questions or concerns regarding completing this worksheet, please ask your Patient Service Representative.

After you complete this worksheet, please return it with your intake forms(s) to the front desk. Thank you.

Name:_____

Are you of Hispanic or Latino origin? (Please check one box).

- ❑ *Yes, Hispanic or Latino*
- ❑ *No, not Hispanic or Latino*

What is your race? (You may choose more than one box).

- ❑ *White*
- ❑ *Black or African American*
- ❑ *American Indian or Alaska Native* _____

(Name of the enrolled or principal tribe)

How well do you speak English?

- ❑ *Very Well*
- ❑ *Well*
- ❑ *Not Well*
- ❑ *Not at All*

Do you speak a language other than English at home?

- ❑ *Yes*
- ❑ *No*

If you answered yes to the question above and speak a language other than English, what is this language?

- ❑ *Spanish*
- ❑ *Other language (identify):*_____

Medication Refill Policy:

- It is your responsibility to notify the office in a timely manner when refills are necessary. Approval of your refill may take up to three (3) business days. If you use a mail order pharmacy, please contact us fourteen (14) days before your medication is due to run out.
- Refills are approved at the discretion of the provider receiving the request. If a covering provider receives a refill request, they may deny the refill request, only fill a limited number of days until the patient's regular provider is available, or refill the prescription.
- Medication refills will only be addressed during regular office hours (Monday-Friday 8am-5pm). No prescriptions will be refilled on Saturday, Sunday or Holidays.
- Refills can only be authorized on medication prescribed by providers from our office. We will not refill medications prescribed by other providers. If your provider is no longer in the clinic and you want to continue care in the clinic, you should be transferred to another provider and scheduled for an appointment. Any refill requests will be at the discretion of the new provider.
- Some medications require prior authorization that may increase time for processing your prescription. Depending on your insurance this process may involve several steps by both your pharmacy and your provider. The providers and pharmacies are familiar with this process and will handle the prior authorization as quickly as possible. Only your pharmacy is notified of the approval status. Neither the pharmacy nor the provider can guarantee that your insurance company will approve the medication. Please check with your pharmacy or your insurance company for updates.
- It is important to keep your scheduled appointment to ensure that you receive timely refills. Repeated no shows or cancellations may result in denial of refills. All prescriptions require a follow up appointment every 3 to 6 months.
- Stimulant medication will not be refilled if you have not seen the provider in 3 months or more.
- If you have any questions regarding medications please discuss these during your appointment. If for any reason you feel your medication needs to be adjusted or changed please contact us immediately.
- New symptoms or events require a clinic appointment. Your provider will not diagnose or treat over the phone.
- Please bring all your prescription bottles (or an updated medication list) with you to your appointment. This is important to make sure that you are taking the correct medications and the correct doses; and we have an up-to-date list of your medications. We will carefully review your medications and write refills at your office visit.
- This policy may be changed at any time without prior notice to the patient or their representative.