TUCKER PSYCHIATRIC

OFFICE USE ONLY

Date	Account #	Doctor

PATIENT INFORMATION

First Name (Legal) | Middle Initial | Last

Address:Street

City | State | Zip

Phone Number | Cell Phone Number

Age | DOB | Sex

Phone # In Case of Emergency

Social Security Number

RESPONSIBLE PARTY INFORMATION

Responsible Party/Custodial Parent (If same as above, skip to insurance information)

Address - Street

City | State | Zip

Phone Number

PRIMARY INSURANCE

Ins. Company Name

Effective Date | Expiration Date

Policy Holder's Name | Relationship to Patient

Policy Number | Group Number

Policy Holder's SS Number | Policy Holder's Date of Birth

Policy Holder's Employer Name

Phone Number

I Consent To Receive Reminder Calls Prior To Appointments. ☐ Yes ☐ No

SECONDARY INSURANCE
(Medicare supplement or secondary insurance)

Ins. Company Name

Policy Holder's Name | Relationship to Patient

Policy Number | Group Number

Policy Holder's SS Number | Policy Holder's Date if Birth

Policy Holder's Employer Name

Phone Number

MOTHER'S INFORMATION

Name | DOB | MAR ST

Social Security Number

Address (if different than patient)

City/State/Zip

Home Phone #

Employer | Work Phone #

Cell Phone #

FATHER'S INFORMATION

Name | DOB | MAR ST

Social Security Number

Address (if different than patient)

City/State/Zip

Home Phone #

Employer | Work Phone #

Cell Phone #

EMERGENCY CONTACT

Name

Relationship to Patient

Address

City/State/Zip

Phone #

Cell Phone #

OTHER INFORMATION

If Medicare: Are you employed? ____ Yes ____ No Are you covered by an employer health insurance? ____ Yes ____ No

REFERRED BY: ☐ (1) FAMILY DOCTOR ☐ PEDIATRICIAN ☐ (2) RELATIVE/FRIEND ☐ INTERNET ☐ INSURANCE CO. ☐ (5) THERAPIST

NAME OF REFERRING DOCTOR ____

CLIENT'S CONSENT TO EXCHANGE INFORMATION

PRIMARY CARE PHYSICIAN

Insurance plans and managed care organizations encourage the exchange of information between this office and your Primary Care Physician (PCP) in order to coordinate medical and psychiatric care. ***Please make a selection below.***

☐ I give consent for information regarding my treatment to be shared with my PCP/Referring Physician/Pediatrician/Therapist as follows:

Name of PCP: ______________________ PCP Phone: ______________________

Located at: ______________________

Name of Therapist: ______________________ Therapist Phone: ______________________

Located at: ______________________

☐ I **do not** wish to have information regarding my treatment with this practice released to my PCP.

INSURANCE CLAIMS PAYMENT

I authorize the release of medical record information or excerpts thereof, to any insurance company or third party payor for utilization management, audit purposes and/or the purposes of verifying the services rendered and obtaining payment of the account. I understand that execution of this authorization waives my right of confidentiality as to the material released pursuant to this authorization.

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS

I understand that I am financially responsible to pay Tucker Psychiatric Clinic (TPC) its usual charges for all services received, including any balances not covered by my insurance carrier(s). I understand that it is the patient's responsibility to obtain any prior authorization or doctor's referral. I understand that failure to meet this requirement may result in a significant loss of benefits. I hereby assign all of my rights to receive any and all insurance proceeds, otherwise payable to me, for coverage(s) provided by my health insurance carrier(s) to TPC, and direct that payment of proceeds be made directly to TPC. Because we reserve your appointment time for you, we charge a fee up to and including our full normal fee, for missed appointments not cancelled at least 24 hours in advance.

My signature below represents that I have read and understand the terms and statements above.

This consent and authorization form will remain in effect for the duration of my treatment unless revoked by me in writing and may not be revoked as to services rendered prior to my notice of revocation. A photocopy of this consent and authorization form is to be considered as valid as an original.

______________________ ______________________

Patient's Signature Date Parent/Guardian's Signature Date

I have witnessed the completion of this authorization form. ______________________

Employee Signature Date

Acknowledgement of Notice of Privacy Practices

I understand I may request a copy of the Tucker Psychiatric Notice of Privacy Practices. I understand that I may ask questions to Tucker Psychiatric if I do not understand any information contained in the Notice of Privacy Practices.

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Patient/Guardian's Signature Date

Third Party Access

I authorize Tucker Psychiatric to disclose current healthcare information with the family/others listed below.

______________________ ______________________

Spouse Parent

______________________ ______________________

Sibling Other

______________________ ______________________

Patient Signature Date Employee Signature Date