SHENANDOAH PSYCHIATRIC MEDICINE

PATIENT NAME_____ TODAYS DATE _____
DATE OF BIRTH _____AGE_____ SOCIAL SECURITY # _____

MOBILE #_____ HOME # _____
* I WOULD LIKE A **TEXT** APPOINTMENT REMINDER **YES** **NO**

EMAIL ADDRESS_____

HOME ADDRESS_____
CITY, STATE,ZIP_____
BIRTH GENDER: **M** **F** GENDER IDENTITY: **M** **F** MARITAL STATUS **S** **M** **D** **W**
[ ] UNEMPLOYED [ ] RETIRED [ ] DISABLED
EMPLOYER OR OCCUPATION_____ EMP.PHONE_____
EMPLOYER ADDRESS_____
EMP CITY, STATE, ZIP_____

NEXT OF KIN (NOK)_____ NOK PHONE #_____
NOK ADDRESS_____ RELATION TO PATIENT_____
NOK CITY, STATE, ZIP_____

INSURANCE COMPANY_____ INS. ID _____
PRIMARY CARE PHYSICIAN_____

Preferred Pharmacy: _____

Allergies:

_____
_____
_____
_____

Medical Problems/ Past Surgeries:

_____
_____
_____
_____
_____
_____
_____

Current Medications:

Name	Dosage	Frequency

Shenandoah Psychiatric Medicine

Summary Financial Responsibility

PAYMENT: Insurance is billed as a service to the patient and does not guarantee payment for services rendered. A payment is due at the **time of service** either full fee, if you are not utilizing insurance or your co-payment/deductible, if we are billing your insurance company. If insurance payment is not received within 90 days of service, responsibility for payment reverts to the patient/guarantor.

Please review and initial the following:

_____ I understand the insurance may be filed for me.
I am responsible for payment of fees regardless of insurance coverage.

_____ I authorize payment from my insurance company to be made directly to SPM.

_____ I understand that bills are sent monthly and are due at time of receipt. Any bill **NOT PAID** within 90 days will be turned over to collections unless other arrangements are made.

_____ I authorize the release of medical information required to process insurance claims and/or to complete Treatment Plans/Reviews required by insurance or managed care companies.

_____ **Reminder texts are a courtesy. It is your responsibility to come to your appointment.

If a patient does not show up for their appointment or if a patient cancels or reschedules their appointment the day of their appointment, they will receive a **$50 NO SHOW FEE.** THE FEE WILL NEED TO BE PAID AT THEIR NEXT VISIT.

_____ _____

Patient Signature or Parent/Guardian **Date**

Shenandoah Psychiatric Medicine

CONTROLLED PRESCRIPTION MEDICATION TREATMENT AGREEMENT

This form is in the event you are prescribed a medication that is regulated by the Federal Drug Enforcement Administration. Substances controlled by the DEA require prescribers to carefully monitor use of the medication, and patients to abide by strict guidelines for use. Please review the following and sign:

I _____, agree to abide by SPM guidelines and all applicable laws for taking controlled prescription medication including:

1. I will take the medication only as prescribed.
2. I will not give, loan, sell, or otherwise distribute the medication to anyone else.
3. I understand that I may be asked for a **Urine Drug Screen** at any time, and if positive for mind-altering substances, medications not prescribed to me, or negative for prescribed medications, this may result in discontinuation of certain medications or discharge from services. **There is a fee of $35.00 for each Urine Drug Screen, INSURANCE DOES NOT PAY FOR**.
4. I understand that SPM prescribers will use the Virginia Prescription Monitoring Program database to check on my compliance with this agreement, and if misuse is shown here, this may result in discontinuation of certain medications or discharge from services.
5. I will not obtain prescription controlled medications from other subscribers without notifying my SPM prescriber.
6. I will fill my medications at the same pharmacy and will notify my SPM prescriber if I switch pharmacies.
7. I will notify SPM at least 4 days in advance for a prescription refill. I understand if medication is lost or stolen, it cannot be replaced until it is due to be refilled.

Printed Name: _____

Signed: _____ Date: _____

SHENANDOAH PSYCHIATRIC MEDICINE

RELEASE OF INFORMATION

I authorize **Shenandoah Psychiatric Medicine (SPM)** to share verbal and/or written evaluation and progress notes with the following:

Primary Care Physician (PCP): _____

Counselor (if you see one): _____

Insurance/Managed Care Company: _____

WHO MAY WE TALK TO ON YOUR BEHALF (IF NEED BE):

_____

*I authorize **SPM** to request and receive from the VA Dept of Health Professions and all records held by them relating to **Schedule II-V CONTROLLED SUBSTANCES.**

*I understand that Shenandoah Psychiatric Medicine may release information from my medical records and billing records in accordance with the provisions of Health Insurance Portability and Accountability Act (HIPPA) and statutory regulations of the Commonwealth of Virginia. My signature below acknowledges that I have read and/or received a copy of the federal Notice of Privacy Practices at or prior to this service encounter.

* ***CONFIDIENTIALITY:*** Patient information will be maintained in accordance with applicable federal and state law, rules, or regulations that authorize disclosure in certain circumstances including but not limited to the following:

i. In the case of child or dependent adult abuse or neglect;
ii. In the case of insurance companies as required for billing and payment;
iii. In the case of subpoenas or court orders;
iv. In the case of any collections proceedings if necessary;
v. In the case of any circumstances where disclosure is permitted or required pursuant to applicable federal or state laws, rules, or regulations.

*I understand that I may **REVOKE this RELEASE** at any time before it expires by providing a written statement to **SHENANDOAH PSYCHIATRIC MEDICINE.** I also understand a failure to sign this **RELEASE** may delay or otherwise hinder my treatment. A photocopy of this **RELEASE** has the same authorization as the original.

_____ _____
Patient Signature **Date**

_____ _____
Parent/Guardian Signature **Date**