



Patient Registration

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____

Preferred Name: _____
Address: _____
City, State, Zip: _____
Preferred Contact Number: _____
Secondary Contact Number: _____
May we leave confidential information on these voicemails? <input type="checkbox"/> Yes <input type="checkbox"/> No

Emergency Contact:

Name: _____ Number: _____

Relationship to the patient: _____

*Preferred Pharmacy Name and Number: _____

Who may we thank for your referral? _____

Please provide a current copy of your insurance card. If the insurance policy holder is someone other than the patient, please list their name and date of birth:



Office Policies and Procedures

Please initial each section after reading. Understanding the way our office works will help you communicate with us in a way that will best meet your needs.

Prescriptions and Refills

All prescriptions should be requested during appointments when your medical record is available to the doctor. Follow up appointments are scheduled to ensure that you do not run out of medications between appointments. If you are low on medication for any reason, please contact us at least several business days before running out rather than waiting until the last moment.

If you require a **phoned in prescription**, a **\$25 fee** will be required.

Please note, Federal and State laws prohibit the dispensing of certain medications without examination.

Refill requests faxed or called into our office by your pharmacy will **not** be honored.

If you have missed or cancelled an appointment, you are responsible to reschedule your appointment in a timely fashion to ensure proper treatment and medication management. Consistent follow up appointments are necessary for safe medical care.

_____ Initials

Lost/Stolen Medications

Medications are the sole responsibility of the patient and may not be replaced if lost or stolen. Always fill out a police report for lost or stolen medications. There is a **\$25 fee** for all **prescriptions written or called in outside of appointment times**.

In general, it is the pharmacy's discretion whether to refill a lost prescription early. The doctor may call on your behalf to request this, but whether the doctor does this will depend on several factors. If the medication you lost is a controlled substance, the pharmacy will most likely NOT be able to fill the prescription early. Our office is NOT responsible for replacing medications early and is held by strict local and federal laws that we must comply with or face penalties.

If you are being prescribed a controlled medication by the doctor, it is expected that you abide by the following rules:

1. Just use one doctor. It is illegal to get controlled prescriptions from more than one provider.
2. If the doctor has any reason at all to suspect that you are abusing, selling, giving away, sharing or otherwise acting irresponsibly with your medications, you may no longer be prescribed your medication and also may be discharged from the practice.
3. **Keep your medications in a safe and well controlled environment.** (Away from access by children, pets, and visitors or in an unwise location such as above the toilet or sink.) It would be preferable if the medications were kept locked up.
4. Police reports are required for lost or stolen medications. (An actual report, not a case number.)
5. Compliance with toxicology testing (urine or saliva screens) and/or medication counts.

6. Be aware that your prescriptions can be monitored through a Prescription Reporting System, which also includes information from nearby states.

_____ Initials

Appointments

Missed appointments represent a cost to us, to you, and to other patients who could have been seen in the time set aside for you. If you are unable to keep your appointment, please give at least 24 business hours notice to avoid a fee. Excessive abuse of scheduled appointments may result in being discharged from the practice.

Doctor visits carry a \$50 no show fee and a \$50 same day cancellation fee. Therapy appointments carry a \$125 fee for no show or same day cancellation due to the length of the reserved time. Established therapy patients may use the reserved time as a phone session, but it will still carry the \$125 charge as insurance does not cover phone appointments.

Patients are seen by appointment and our office makes every effort to provide courtesy reminder calls; however it is your responsibility to keep all scheduled appointments.

Please note there may be difficulty rescheduling you when we are provided short notice if your provider is booked out. We do try to keep a cancellation list to offer sooner appointments, however this is provided as a courtesy on a first come, first served basis and does not guarantee earlier visits.

_____ Initials

Children and Pet Policy

We love children and pets, but please only bring pictures. In our efforts to offer a relaxing and professional atmosphere where you can focus on your treatment, we ask that you refrain from bringing your guests (not involved in treatment), children, and pets to the office. Our practice caters to adult care and is not appropriate for children. We are unable to provide childcare while you are being treated.

_____ Initials

Emergencies

If you feel you need urgent medical care please call 911, go to the nearest hospital emergency room, or call Palmetto Lowcountry Behavioral Health (PLBH) at 843-747-5830. A doctor's referral is not needed for admission to PLBH.

_____ Initials

Telephone Policy

Office Phone Calls

We take pride in answering your call in person whenever possible. However, there are times when heavy call volume or patient load may prevent us from speaking with you directly. If you get a recording, you will obtain best results by observing the following directions:

- Plan ahead and call once. Multiple calls add more delay in returning your call.
- Keep your message brief.
- Allow ample time for a return call, especially if you call late in the day.
- Office Staff will be polite and respectful. They deserve the same in return.
- Abusive or threatening calls will be reported.

Clinical Phone Calls

We encourage you to call with questions regarding your medical care. To uphold quality of care and fairness to all, providers **cannot** take time from patient appointments to accept or return patient phone calls. **Medical Assistants** are available to speak with you about questions and/or concerns which will then be presented to your provider for review. This is the **fastest and most efficient way to communicate with your provider outside of appointments**.

If you still feel that you must speak directly with your provider, we will make every effort to get you an earlier appointment. **Phone or video appointments are available** with your provider at a **self-pay fee** as insurance policies do not currently cover these types of visits.

_____ Initials

Payment Policy

Health care regulations require us to collect all co-payments, deductibles, and non-covered service fees or face charges of fraud. **Payment is due in full at the time of service**. We accept cash, checks, VISA, MasterCard, Discover and American Express. You may also pay your bill online.

Please remember that the responsibility for the payment of medical bills rests with you, the patient. We will gladly file with your insurance company, but cannot influence their policies regarding the extent or amount of payment.

In the event of financial hardship, please contact our office in advance to make payment arrangements. In most cases, we can arrange scheduled payment plans or refer you to a facility that offers a sliding scale.

We reserve the right to use additional billing or collection agencies for delinquent accounts.

_____ Initials

Letters and Forms

Any forms or reports that must be completed by your provider as requested by you or a third party are subject to a charge. You can have the form filled out during the office visit or drop off the paperwork. Please be considerate and allow 14 business days for letters and forms to be completed. To expedite the filling out of the form, you should complete parts of the form that you can fill in like your name, address, etc.

_____ Initials

Waiting Room Courtesy

- Please check in with the receptionist or sign in upon your arrival.
- Patient comfort and privacy is of utmost importance to us. Please do not disturb others who are waiting. Respect everyone's comfort level.
- Please refrain from talking on your cell phone.
- Limit messy food and drink.
- Avoid wearing heavy perfumes or oils in consideration of patients or staff with chemical sensitivities.
- To reduce wait time at the reception window, please avoid lengthy conversation, have payment and scheduling tools ready, and avoid taking calls on your cell phone.
- Smoking or e-cigarettes are NOT permitted anywhere in our building.

_____ Initials

Illegal activity on Barrier Islands Psychiatry property or abusive/threatening language or behavior will result in immediate and permanent discharge from the practice. _____ Initials



Please be advised that the patient is responsible for providing a current copy of their insurance card. The patient is responsible for obtaining and providing a referral when required by the insurance company. Without the required information, it is the responsibility of the patient to pay for services rendered on the day of the visit.

Health care regulations require us to collect all co-payments, deductibles, and non-covered service fees or face charges of fraud.

By signing below, I authorize payment of insurance benefits to Barrier Islands Psychiatry for any medical services provided to me. I accept personal responsibility for all services rendered to me, and understand that I am responsible for any charges not covered by my insurance company.

I understand that I will be charged, and agree to pay, for any appointments that I fail to keep and do not cancel at least 24 hours in advance. I understand that failure to pay as outlined above may result in additional billing, collection agency, and/or legal fees for which I will also be responsible.

Signature of Patient

Date

Consent and authority is hereby given to Barrier Islands Psychiatry and its professional staff to perform or have performed examinations and/or psychotherapy and/or related mental health treatments and to administer medications when deemed necessary or advisable by appropriate members of the professional staff in consultation with me. This statement has been fully explained to me (if needed) and I understand it.

Signature of Patient

Date

I have been provided a copy of the NOTICE OF PRIVACY PRACTICES and had an opportunity to review it and ask questions.

Signature of Patient

Date

I have been provided a copy of the OFFICE POLICIES AND PROCEDURES and had an opportunity to review it and ask questions.

Signature of Patient

Date



Reason you are seeking care:

How long have you suffered with these symptoms? _____

Have you ever met with a mental health professional? Yes No

Where and when?

Have you ever been treated inpatient at a psychiatric hospital? Yes No

Where/When?

Circle any of the following medications you have ever taken. If effective, put a **check** next to it:

- | | | |
|----------------------|-----------------------|------------------------|
| Abilify/Aripiprazole | Fanapt/Iloperidone | Ritalin |
| Adderall/Dextrostat | Fetzima | Seroquel/Quetiapine |
| Ambien/Zolpidem | Geodon/Ziprasidone | Strattera |
| Amitriptyline | Keppra | Suboxone/Subutex |
| Antabuse/Disulfiram | Klonopin/Clonazepam | Symbyax |
| Ativan/Lorazepam | Lamictal/Lamotrigine | Tegretol/Carbamazepine |
| Brintellix | Latuda/Lurasidone | Topamax/Topiramate |
| Buspar/Buspiron | Lexapro/Escitalopram | Trazodone/Oleptro |
| Campral | Lithium/Lithobid | Trintellix |
| Celexa/Citalopram | Lunesta/Eszopiclone | Viibryd/Vilazodone |
| Clonidine | Neurontin/Gabapentin | Vivitrol/Naltrexone |
| Concerta | Paxil/Paroxetine | Vyvanse |
| Cymbalta/Duloxetine | Pristiq | Wellbutrin/Bupropion |
| Daytrana Patch | Prozac/Fluoxetine | Xanax/Alprazolam |
| Depakote/Valproate | Remeron/Mirtazapine | Zoloft/Sertraline |
| Effexor/Venlafaxine | Rexulti | Zyprexa |
| | Risperdal/Risperidone | |

Please list other mental health medications you have taken that were not listed:

Allergies to any medications (describe reaction)? _____

Do you have a history of substance abuse? Yes No

Which Substance(s)?

Do you use tobacco (type/amount)? _____

Do any of your family members have a mental illness or addiction? _____

Have you ever had any surgeries (please list)? _____

Do you have any medical problems (please list)? _____

List medications you are currently taking. Please include dose if known:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please list your primary care doctor's name and location: _____

Other information you wish your provider to be aware of:
