CHILD/ADOLESCENT
ESTABLISHED PATIENT
PACKET

PATIENT INFORMATION

Today's Date _____

LEGAL NAME: _____
(first) (middle) (last)
Nickname or Name you go by: _____ AGE: _____ **DATE OF BIRTH**: _____

ADDRESS: _____
(street) (apt/suite) (city) (state) (zip code)
RACE: [ ] American Indian or Alaska Native [ ] Asian [ ] Black or African American [ ] White
[ ] Native Hawaiian or Pacific Islander [ ] Hispanic or Latino [ ]Other : _____

SEX: [ ] M [ ] F **Gender Identity:** _____ **Grade in School:** _____ **PCP:** _____

Please Choose One: We provide a *courtesy* reminder for your appointments either by: [ ] Email **or** [ ] Text

PRIMARY CONTACT: Parent Name _____ Relation to Patient _____

Primary Phone # _____ **IS A:** [ ] cell [ ] home [ ] work [ ] other _____

Primary Email: _____ (reminders will be sent to the primary contact)

SECONDARY CONTACT: Parent Name _____ Relation to Patient _____

Secondary Phone # _____ **IS A:** [ ] cell [ ] home [ ] work [ ] other _____

Secondary Email: _____

PREFERRED PHARMACY_____
(store name) (address) (phone)

Other family members seen here: _____

INSURANCE INFORMATION

[ ] NO COVERAGE / SELF PAY – *if you are opting out of using your insurance please fill out our opt-out form*

[ ] FILE TO MY INSURANCE – *Please provide us with a current and up to date copy of your insurance card at each visit*

INSURANCE CARRIER _____**POLICY TYPE**_____

MENTAL HEALTH COVERAGE (if different than main carrier) _____

Member ID_____ Person #_____ Group #_____

Policy Holder/Subscriber: Name_____ Relationship to patient_____

Subscriber's Address_____

Subscriber's Date of Birth_____ Sex [ ] M [ ] F Subscriber SS# _____

Person responsible for bill (if different than policy holder) _____

Address to send bills to _____

Please read thoroughly then sign and date stating that you have read and agree to abide by all office policies for Peace Psychiatry

NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices is attached to this clipboard, if not, our office staff can provide you with one. It is also posted on our website at www.peacepsychiatry.com. By signing below, you acknowledge receipt of this notice and/or know how to access this notice. You may refuse to sign this acknowledgement; however, should you refuse to sign, Peace Psychiatry, PLLC will not be able to file to your insurance and you would be fully responsible for all charges.

MISSED APPOINTMENT POLICY

Peace Psychiatry charges for missed appointments or any appointment that is canceled with less than 24 hours' business day notice. You must contact the front office staff to cancel and reschedule appointments. Appointment reminders (texts/emails) are provided only as a courtesy. We ask that you do not solely rely on reminders, you are ultimately responsible for keeping a record of the day and time of your appointments. It is our policy to collect the missed appointment fee prior to rescheduling a new appointment. *Your doctor has the right to close your chart and refer you elsewhere if you do not follow up as recommended.*

FINANCIAL & INSURANCE POLICY

Our practice is committed to providing the best treatment for our patients and we charge the usual and customary rates for our area. **Full payment is due at the time of service.** We accept cash, check, money order, Visa, MasterCard, Discover, or American Express. Our office does not intervene with family disputes; it is the guardians' responsibility to provide payment at the time services are rendered.

Our providers are credentialed and have contracts with several insurance networks. It is your responsibility to check if your doctor is in-network with your mental health carrier. To find out this information, we recommend you call your insurance company prior to your visit. We file with primary insurance only and do not file out-of-network or secondary insurance claims. If we are not contracted with your insurance carrier, you are responsible for full payment at the time of service. If your insurance requires an authorization for your visits, you are responsible to obtain that authorization prior to your appointment. If you have a deductible, you are responsible for paying for your portion in full at the contracted rate for your insurance carrier until you have met your deductible obligation with that carrier. If your insurance carrier requires a co-payment or a co-insurance, this is to be paid at each visit.

You are responsible for payment of services rendered regardless of any determination made by an insurance company. Insurance will not pay for missed appointments. Unless canceled at least 24 hours (business day) in advance, it is our policy to charge the office visit rate for the missed appointment. It is also your responsibility to notify the office if you have a change in insurance coverage and provide us with an up to date insurance card at each visit. We collect the patient responsibility (portion/copay) at the time services are rendered. For this reason, we recommend you call your insurance and find out your mental health office visit benefits prior to your appointment, thenceforth you will be prepared to pay your portion. Please let us know if you have any questions or concerns regarding our financial policy.

By signing below, you have read and agree to all of the above and the following statements:

The information I have provided to the office is true, to the best of my knowledge. I authorize Peace Psychiatry, PLLC to release any information required to process my claims and to have my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance or denial of claims. I understand that Peace Psychiatry has the right to refuse services if I violate any of the office policies.

Signature: _____ Date Signed: _____