

S | P | A  
S O U T H A M P T O N  
psychiatricassociates

REGISTRATION FORM

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Name \_\_\_\_\_ Sex \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_  
Last First MI

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Marital Status  Minor  Single  Married  Divorced  Widowed  Separated

Employment  Full Time  Part time  Minor  Unemployed  Disability

Employer Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

If Student  Full Time  Part Time School/College \_\_\_\_\_

School Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Referred by \_\_\_\_\_  MD  Ph.D  Therapist

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_

Family Dr/Pediatrician \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Responsible Party Name \_\_\_\_\_ DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Relationship to Patient \_\_\_\_\_ Social Security # \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer \_\_\_\_\_ Address \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

**Primary Insurance Information – must be complete in order to bill insurance**

Name of Insured \_\_\_\_\_ DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Soc Sec # \_\_\_\_\_

Insurance Company Name \_\_\_\_\_ Telephone \_\_\_\_\_

ID # \_\_\_\_\_ Group \_\_\_\_\_

Employer \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

**Secondary Insurance Info, if applicable – must be complete in order to bill insurance**

Name of Insured \_\_\_\_\_ DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Soc Sec # \_\_\_\_\_

Insurance Company Name \_\_\_\_\_ Telephone \_\_\_\_\_

ID # \_\_\_\_\_ Group \_\_\_\_\_

Employer \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

**Prescription Drug Coverage – must be complete in order to obtain prior authorization or pre certification**

Company Name \_\_\_\_\_ ID # \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

**If Patient is under 18, please complete the following if applicable**

Noncustodial parent information

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Ph \_\_\_\_\_ Cell Ph \_\_\_\_\_

**The following statements MUST be signed by ALL patients, age 14 and over. If patient is under 14, parent must sign**

My signature below indicates that I have read and understood the office policies of Southampton Psychiatric Associates. I also understand that failure to pay for any services rendered not covered by my insurance can result in legal action.

Signature \_\_\_\_\_ Relationship to patient \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

I give my consent to Southampton Psychiatric Associates to evaluate and/or treat myself.

Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

I give my my consent to Southampton Psychiatric Associates to evaluate and/or treat my child under the age of 14.

Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**The following statements must be signed by patients aged 14 and over, in order for Southampton Psychiatric Associates to bill any insurance. If patient is under 14, parent must sign**

Release of Information I authorize the release of any medical or other information necessary to process any insurance claims. I also request payment of benefits either to myself or to the party who accepts assignment.

Signature \_\_\_\_\_ Relationship to patient \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

I authorize payment of medical benefits to the undersigned physician or supplier of services described.

Signature \_\_\_\_\_ Relationship to patient \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**FOR PERSONAL CHOICE PATIENTS ONLY (please indicate one)**

I do /  do not

wish for my primary care physician to be informed periodically of my treatment at Southampton Psychiatric Associates.

Signature \_\_\_\_\_ Relationship to patient \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**If your primary care physician is to be informed of your treatment, the following information must be completed**

Primary Care Physician Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

**Receipt of Notice of Privacy Practices  
Written Acknowledgement Form**

I, \_\_\_\_\_ ,  
have received a copy of Southampton Psychiatric Associates Notice of Privacy Practices.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

If this acknowledgement is signed by a personal representative on behalf of the client, complete the following:

Personal Representative's Name \_\_\_\_\_

Relationship to Client: \_\_\_\_\_

---

---

**FOR OFFICE USE ONLY**

I attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- An emergency situation prevented us from obtaining the acknowledgement
- Communication barriers prohibited obtaining the acknowledgement
- Other (please specify):  
\_\_\_\_\_

This form will be retained in your medical record

**PATIENT MEDICAL HISTORY FORM**

NAME \_\_\_\_\_ DATE \_\_\_\_\_

OCCUPATION \_\_\_\_\_ BIRTHDATE \_\_\_ / \_\_\_ / \_\_\_ AGE \_\_\_\_\_ GENDER  MALE  FEMALE

ALLERGIES TO MEDICATIONS, X-RAYS, DYES OR OTHER SUBSTANCES: \_\_\_\_\_

\_\_\_\_\_

NONE

**CURRENT MEDICATIONS, VITAMINS, SUPPLEMENTS, HERBS – PRESCRIPTION AND OVER-THE-COUNTER**

(LIST NAME AND DOSE):  NONE

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PAST MEDICAL HISTORY AND REVIEW OF SYMPTOMS**

<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Change in bowel habits	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Skin Diseases
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Unexplained weight loss/gain	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Asthma
<input type="checkbox"/> Cancer	<input type="checkbox"/> Persistent cough	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Low back problems	<input type="checkbox"/> Blood in stool
<input type="checkbox"/> Anemia	<input type="checkbox"/> T.B.	<input type="checkbox"/> Gall bladder disease	<input type="checkbox"/> Numbness of arms/legs	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Heart disease	<input type="checkbox"/> Hay fever	<input type="checkbox"/> Colitis	<input type="checkbox"/> Headache	<input type="checkbox"/> Depression
<input type="checkbox"/> Chest Pain/tightness	<input type="checkbox"/> Abdominal discomfort	<input type="checkbox"/> Bruise easily	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Alcohol abuse
<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Indigestion	<input type="checkbox"/> Thyroid disease	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Drug Abuse
<input type="checkbox"/> Swollen ankles	<input type="checkbox"/> Nausea/Vomiting	<input type="checkbox"/> Head or neck radiation	<input type="checkbox"/> Difficulty Passing urine	<input type="checkbox"/> Gout
<input type="checkbox"/> Palpitations	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Lightheadedness	<input type="checkbox"/> Difficulty holding urine	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Constipation	<input type="checkbox"/> Frequent urination	<input type="checkbox"/> Sleep problems	
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Sexually transmitted disease	<input type="checkbox"/> Blood disorders		

**GYNECOLOGIC AND OBSTETRIC HISTORY: WOMEN ONLY**

Age at onset of periods: \_\_\_\_\_ Pregnancies: \_\_\_\_\_

Last menstrual period: \_\_\_\_\_ Births: \_\_\_\_\_

Frequency: \_\_\_\_\_ Miscarriages: \_\_\_\_\_

**OPERATIONS & HOSPITALIZATIONS (LIST YEAR AND TYPE OF OPERATION OR DIAGNOSES AFTER HOSPITALIZATION)**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

IMMUNIZATION HISTORY	YEAR	OTHER VACINES	YEAR
Last Tetanus Shot?	_____	Lyme Vaccine?	_____
Pneumovax Shot?	_____	Hepatitis A Vaccine?	_____
Flu Shot?	_____		
Hepatitis B Vaccine?	_____		

SCREENING TESTS (LAST ONE)	YEAR		YEAR
Mammogram?	_____	Breast exam?	_____
Pap Smear?	_____	Cholesterol Check?	_____
Stool check for blood?	_____	Prostate Exam?	_____

FAMILY HISTORY ILLNESS	GRAND FATHER	GRAND MOTHER	FATHER	MOTHER	BROTHER	SISTER	CHILD	AGES WHEN DIAGNOSED
	Cancer (type)							
Hypertension								
Diabetes								
Stroke								
Mental Disease (anxiety, depression)								
Drug or Alcohol addiction								
Glaucoma								
Bleeding diseases								
Other:								

**PREVENTION**

Do you wear seat belts? Yes No      Women: Do you perform self breast exams? Yes No

Do you wear a bike helmet? Yes No      Men: Do you perform self testicular exams? Yes No

Do you smoke? Amount: \_\_\_\_\_ Yes No      Do you exercise regularly? Yes No

Do you drink alcohol beverages? Yes No      Are you following a specific diet? Yes No

Do you drink coffee? Amount: \_\_\_\_\_ Yes No      If so, type of diet: \_\_\_\_\_

Do you drink tea? Yes No      Do you ever feel afraid of your partner? Yes No

Is there a gun in your home? Yes No      Do you have a living will? Yes No

Do you use drugs? Type: \_\_\_\_\_ Yes No      Do you have a donor card? Yes No

Have you ever engaged in any activity which would put you at risk of AIDS? ..... Yes No

Have you ever worked with chemicals, paints, asbestos or other hazardous material? ..... Yes No

**OFFICE POLICIES**

**FEES AND PAYMENTS**

A \$15.00 service charge will be applied to your account if payment is not received at the time of your visit. If you are going out of your insurance network, the office will provide you with a receipt that you can submit to your insurance company. All of the necessary information required by your insurance company is on the receipt.

There will be a \$30 service charge for all checks returned for non-sufficient funds. We will no longer accept payment by check if more than two checks are returned. Payment will then need to be made by cash or Visa/Mastercard.

**NEW FEE SCHEDULE AS OF 03/01/2011**

**PSYCHIATRY:**

Evaluation session.....	\$225
45 minute session .....	\$185
20/30 minute session.....	\$135
Brief medication session.....	\$ 75

**PSYCHOLOGY:**

Evaluation session.....	\$200
Full therapy session .....	\$150
Group session .....	\$ 45

**SOCIAL WORKERS**

**LICENSED PROF. COUNSELORS**

Evaluation session.....	\$160
Full therapy session .....	\$135
Group Session.....	\$ 45

*\*\*Please be aware that this is the first increase in our fees since 2007*

**PROPERTY DAMAGE**

If the office or bathrooms are damaged by your child, you will be charged the cost of repairing that damage.

**APPOINTMENTS**

All patients are seen by appointment only. This office has a 24-hour cancellation policy. **FULL FEE (ACCORDING TO THE ABOVE FEE SCHEDULE) IS CHARGED FOR ALL MISSED APPOINTMENTS OR APPOINTMENTS CANCELLED WITH LESS**

**THAN 24 HOURS NOTICE.** Monthly payments may be made towards missed/broken appointments. However, the balance must be paid in full within six months.

If you have not been seen for six months, your chart will be closed. If you decide to return to the practice, you will be considered a new patient. This will require a new evaluation.

**PHONE CALLS**

Phone calls are taken in the office between 8:30 a.m. and 4 p.m. Monday through Friday. If a true emergency arises after these times, the answering machine will instruct you to contact our answering service. The answering service will contact the appropriate member of the Practice. All calls for prescription renewals must be placed by 3 p.m. Any requests for prescriptions that are made after 3 p.m. will be phoned into your pharmacy the following day (Monday through Friday). Requests made for prescriptions on the weekends will be phoned in by the physician on call. You will be given only enough medication until Monday.

**FEES FOR SERVICES NOT COVERED BY INSURANCE**

*Letters Requested by Patient:*

\$15-\$50 (depending on provider's time)

*Forms Requested by Patient:*

\$15-\$50 (depending on provider's time)

*Medical Record Copies:*

\$15 plus \$1.00 per page

*Psychiatric Evaluation Report:*

\$150 - \$250

**WE REQUIRE 10 DAYS NOTICE FOR ANY OF THE ABOVE SERVICES. IF YOU REQUIRE THESE SERVICES SOONER THAN 10 DAYS, THERE WILL BE A \$25 ADDITIONAL SURCHARGE.**

**FEES FOR THE FOLLOWING SERVICES ARE PRORATED & BASED ON THE PROVIDER'S FULL-SESSION FEE:**

Non-Emergency phone calls over ten (10) minutes

Reports

School Meetings (including travel time)