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SOUTHAMPTON

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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 Pyschiatric 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_____

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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

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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

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

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

NAME _____ DATE _____

IMMUNIZATION HISTORY	YEAR	OTHER VACCINES	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	Grandfather	Grandmother	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

FEES AND PAYMENTS

A **$15 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 the necessary information required by your insurance company is on the receipt.

There will be a **$30 service charg**e 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, Visa/Mastercard, Discover or American Express.

FEE SCHEDULE AS OF 1/1/2021

PSYCHIATRY	
Evaluation	$250
45 minute session	$220
20/30 minute session	$180
Brief medication session	$95
PSYCHOLOGY	
Evaluation	$210
Full therapy session	$170-$180
Group session	$45
LICENSED PROFESSIONAL COUNSELORS/SOCIAL WORKER	
Evaluation	$165
Full therapy session	$145-$155
Group session	$45

ADDITIONAL SERVICES

Letters or Form completion requested by patient
$15-50 (based on provider's time)
Medical Record Copies $15 plus $1 per page
Psychiatric Evaluation Report $150-$250
Lost Prescription $15

PRORATED SERVICES BASED ON TIME

Nonemergent phone calls over 10 minutes
Reports
School Meetings (including travel time)

APPOINTMENTS

All patients are seen by appointment only. The 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. Repeated missed or broken appointments can result in termination of your care.

If you have not been seen within 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 am and 4 p.m. Monday through Friday. If a true emergency arises after hours, the answering machine will instruct you to contact our answering service. The answering service will contact the appropriate member of the Practice.

PRESCRIPTIONS

The patient must be up to date with appointments for prescriptions to be renewed. All calls for prescription renewals must be placed by 3 p.m. Any requests made after 3 p.m. Will be phoned to your pharmacy the following business day. Requests made for prescriptions on the weekend will be phoned in by the physician on call. However, you will only be given enough medication until Monday. The practice does not acknowledge prescription requests via fax or phone from pharmacies. There is a $15 fee for lost prescriptions

PROPERTY DAMAGE

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