

S | P | A
SOUTHAMPTON
psychiatricassociates

REGISTRATION FORM

Date _____/_____/_____

Name _____		Sex _____		DOB _____/_____/_____		
Last	First	MI				
Address _____						
City _____		State _____		Zip _____		
Phone _____			Cell Phone _____			
Marital Status	<input type="checkbox"/> Minor	<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed	<input type="checkbox"/> Separated

Employment	<input type="checkbox"/> Full Time	<input type="checkbox"/> Part time	<input type="checkbox"/> Minor	<input type="checkbox"/> Unemployed	<input type="checkbox"/> Disability
Employer Name _____			Phone _____		
Address _____					
City _____		State _____		Zip _____	

If Student	<input type="checkbox"/> Full Time	<input type="checkbox"/> Part Time	School/College _____		
School Address _____					
City _____		State _____		Zip _____	

Referred by _____	<input type="checkbox"/> MD	<input type="checkbox"/> Ph.D	<input type="checkbox"/> 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 ____/____/____ SocSec # _____
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 ____/____/____ SocSec # _____
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

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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

<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	Grandfather	Grandmother	Father	Mother	Brother	Sister	Child	AGESWHEN DIAGNOSED
	Cancer (type)							
Hypertension								
Diabetes								
Stroke								
Mental Disease (anxiety, depression)								
Drug or Alcohol addiction								
Glaucoma								
Bleeding diseases								
Other:								

PREVENTION			
Do you wear seat belts?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Women: Do you perform self breast exams?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you wear a bike helmet?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Men: Do you perform self testicular exams?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you smoke? Amount: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you exercise regularly?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you drink alcohol beverages?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you following a specific diet?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you drink coffee? Amount: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	If so, type of diet: _____	
Do you drink tea?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you ever feel afraid of your partner?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is there a gun in your home?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have a living will?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you use drugs? Type: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have a donor card?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever engaged in any activity which would put you at risk of AIDS?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Have you ever worked with chemicals, paints, asbestos or other hazardous material?	<input type="checkbox"/> Yes <input type="checkbox"/> 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 **\$50 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, Visa/Mastercard, Discover or American Express.

FEE SCHEDULE AS OF 6/1/2022

PSYCHIATRY

Evaluation	\$275
45 minute session	\$225
20/30 minute session	\$190
Brief medication session	\$100

PSYCHOLOGY

Evaluation	\$215
Full therapy session	\$175-\$185
Group session	\$50

LICENSED PROFESSIONAL COUNSELORS/SOCIAL WORKER

Evaluation	\$165
Full therapy session	\$145-\$155
Group session	\$45

ADDITIONAL SERVICES

Letters or Form completion requested by patient
\$25-100 (based on provider's time)

Medical Record Copies \$20 plus \$1 per page

Psychiatric Evaluation Report \$200-350

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.