PSYCHIATRIC ASSOCIATES OF WEST MICHIGAN, PLC

PLEASE PRINT Date: _____

Patient Name: _____ Sex: M F

First Mid Int. Last

Date of Birth: _____ Social Security: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Daytime Phone: _____ Evening Phone: _____

Additional Phone: _____ Pager: _____

Patient's Employer: _____

City/State Where Located: _____

Primary Care Physician: _____

Address or Phone: _____

Current Therapist: _____ Phone: _____

Who referred you to our office?: _____

In the event that we need to contact you or return your call, may we leave a message?

On an answering machine? Yes _____ No_____

With another person at above #'s? Yes _____ No _____

FOR MINOR CHILDREN OR PATIENTS WITH GUARDIANS:

(In divorce situation please list person patient resides with first)

Parent/Guardian #1: _____ Relationship: _____

Parent #1 Date of Birth: _____

Address: _____

Contact #1: _____ Contact #2: _____

Parent/Guardian #2: _____ Relationship: _____

Parent #2 Date of Birth: _____

Address: _____

Contact #1: _____ Contact #2: _____

PRIMARY INSURANCE COMPANY: _____

Name of Policy Holder: _____ Sex: M F

Relationship to Patient: _____ DOB: _____ Soc. #: _____

Contract/Member ID: _____ Group: _____

SECONDARY INSURANCE COMPANY: _____

Name of Policy Holder: _____ Sex: M F

Relationship to Patient: _____ DOB: _____ Soc. #: _____

Contract/Member ID: _____ Group: _____

ALL COPAYS ARE DUE AT TIME OF SERVICE.

INSURANCE RELEASE:

I authorize the release of any information my physician may feel is necessary to process my insurance claims. This may include information about my mental health. I authorize participating insurance payments directly to my provider. I fully understand that I will be responsible for any amounts due following a response from my insurance, including deductible and non-covered services. I understand that if I have an insurance that Psychiatric Associates does not participate with that I am responsible for payment in full at the time of service and I will be provided with a claim form to turn into my insurance company for any reimbursement.

_____ Date: _____

Signature of Patient/Parent/Guardian

PSYCHIATRIC ASSOCIATES OF WEST MICHIGAN, PLC
FINANCIAL POLICY

Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require that you sign prior to any treatment.

IF WE DO NOT PARTICIPATE WITH YOUR INSURANCE COMPANY
PAYMENT IN FULL IS DUE AT THE TIME OF SERVICE
WE ACCCEPT CASH, CHECKS, AND VISA/MASTERCARD/DISCOVER

Regarding Insurance:

We participate with several insurance companies which may or may not be yours. Participation means that we will accept what your insurance company approves. You are responsible for any copays, deductibles or non-covered services at the time of service.

Usual and Customary:

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's determination of usual and customary rates.

Minor Patients:

The parent/guardian that accompanies the minor is responsible for full payment at the time of service regardless of what any divorce settlement might say.

Collection Costs:

You are in default if you fail to comply with the terms of this agreement, including failing to make a required payment when due. If you default we will turn your account over to our collection agency and we may choose to also charge you for any reasonable collection costs that are incurred by us.

Appointment Cancellation:

If you must cancel an appointment, you must do so at least **24 hours in advance** in order to avoid a charge up to the full cost of the appointment. Late cancellations and no shows are not billable to insurance companies and are your responsibility. For your convenience we do have 24hour voice mail.

Prescription Refills:

In the event that a prescription refill is necessary prior to your regularly scheduled appointment, please **allow 48 hours' notice.** There will be a charge of $10.00 for refills of controlled substances. This charge is your responsibility and is not covered or reimbursed by your insurance company.

I have read the above financial policy and understand that I am financially responsible for all charges for services that I receive, including the balance remaining after payment of possible insurance benefits.

_____ _____

Signature of Patient or Guardian **Date**

MEDICAL HISTORY

NAME:_____ **DATE OF BIRTH:**_____ **DATE:**_____

List all current medications:

Are you allergic to any medications? If so, please list:

Surgical History:

Please circle any of the below conditions that you are currently being treated for:

Diabetes	High Blood Pressure	Heart Disease
Lung Disease	Cancer	Kidney Disease
Liver Disease	Epilepsy/Seizures	Strokes

Please check the symptoms you have experienced in the last two weeks:

YES	NO	CONSTITUTIONAL	YES	NO	ENDOCRINE
		Decreased Appetite			Heat or Cold Intolerance
		Tiredness/Fatigue			PMS
		Fever			Hair Loss
		CARDIOVASCUALR			PULMONARY
		Increased Heart Rate			Shortness of Breath
		Chest Pain			Cough
		Irregular Pulse			Wheezing
		DERMATOLOGIC			MUSCULOSKETAL
		Rash or Itching			Back/Joint Pain
		Psoriasis			Weakness
		HEENT			NEUROLOGIC
		Dry Mouth			Headaches
		Decreased Hearing			Tremors/Tics
		Difficulty Swallowing			Dizziness/Fainting
		Blurry Vision			Numbness/Tingling
		GASTROINTESTINAL			GU
		Increased Appetite			High Libido
		Nausea/Vomiting			Low Libido
		Constipation			Difficulty Urinating
		Diarrhea			Incontinence/Urgency
		Abdominal Pail			Erectile Problems
		HEMATOLOGIC			Painful Urination
		Swollen Glands			ALLERGIES
		Easily Bruise			Hay Fever