

PATIENT REGISTRATION

Patient Name _____ Sex: M F Date of Birth _____

Address _____ City/State/Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email Address _____ Marital Status S M W D Par Age _____ SS# _____

Employment Y N _____ Student Y N _____

Primary Care Physician _____ Address/Phone _____

Referred by _____ OK to leave messages at home phone? Yes _____ No _____

Emergency Contact _____ Phone _____ Rel. _____

If the patient is a minor: The child lives with Both Parents _____ Mother _____ Father _____

If the parents are divorced or separated, the PARENT WHO BRINGS THE CHILD will be the guarantor of this account

Mother/Guardian _____ Phone _____ Address _____ SAA

Father/ Guardian _____ Phone _____ Address _____ SAA

Primary Insurance Co. _____ Secondary Insurance Co. _____

Subscriber Name _____ Copay\$ _____ Subscriber Name _____ Copay\$ _____

Rel.: Self Spouse Child DOB: _____ Rel.: Self Spouse Child DOB: _____

Employer _____ SS# _____ Employer _____ SS# _____

I give permission for clinicians at Diane Eden MD & Associates Inc to evaluate and treat me or the person for whom I am the legal guardian. I also authorize tests, procedures and medications deemed necessary and mutually agreed upon by me and the clinician(s). I understand that I am responsible for payment to Diane Eden MD & Associates Inc for any services rendered to me or my minor child. I understand that if I cancel an appointment with less than 24 business hours notice or if I do not show up to a scheduled appointment that I have not cancelled, that I will be billed for the appointment time reserved and that my insurance company will not cover this charge. I understand this charge must be paid prior to the next date of service. I understand a \$25.00 billing fee will be added for fees not paid at the time of service. I understand that I am financially responsible for payment for all co-payments, deductibles, coinsurance and any other charges deemed my responsibility and not covered by my insurance company, and that these charges are to be paid at the time of service. I understand that I am responsible for payment if referrals required by my insurance are not obtained by me. If Diane Eden MD & Associates Inc files insurance claims on my behalf, I hereby authorize payment to Diane Eden MD & Associates Inc for such services. I permit a copy of this authorization to be used in place of the original. I understand that if my account balance should go over 60 days that I will be expected to pay in full and seek reimbursement from my insurance company unless other arrangements have been made with the billing department. I understand that after 60 days, my account will incur finance charges and late charges. I understand that the parent who brings in a minor for treatment is the financially responsible party. Should my account be referred to a collection agency, I am aware that I will be responsible for all fees associated. I authorize and give consent to Diane Eden MD & Associates Inc to discuss my care and relevant financial information with attorneys, accountants, insurance carriers (malpractice and health), billing agents and collection companies as deemed necessary. This release includes all services relating to my medical care.

Patient/Guardian Signature _____ Date _____

Clinician _____ DSM IV _____ Date _____

Clinician _____ DSM IV _____ Date _____

Clinician _____ DSM IV _____ Date _____

Diane Eden MD & Associates Inc
Treatment and Financial Policy

This is an agreement between Diane Eden MD & Associates and the Patient or Guardian of the registered patient. By signing this agreement, you agree to its terms. You may ask for a copy of this agreement.

MEDICARE PATIENTS ONLY

I request payment of authorized Medicare benefits be made on my behalf to Diane Eden MD & Associates, Inc for any services to myself, my child or another person for whom I am the legal guardian. I authorize any holder of medical information about me, to release to the Center for Medicare and Medicated Services or its agents, any information necessary to determine benefits payable for related services. If the appropriate items of the HCFA-1500 claim form are completed, I understand that my signature authorizes release of necessary information to the insurer or agency necessary to secure payment. In Medicare assigned cases, the clinician agrees to accept the Medicare UCR, and I am only responsible for the difference between Medicare's allowed amount and the insurance payment. I understand that all deductibles, co-payments and co-insurance fees are due from me at the time of service. I understand that I may be billed a surcharge if I do not pay my co-payment, deductible or coinsurance at the time of my appointment.

Patient/Guardian Signature _____ **Date** _____

SELF-PAY

In the event that I do not provide my current/updated health insurance, or if I do not provide any health insurance information, I understand that I will be considered to be requesting services on a self-pay basis. I understand that payments are due in full at the time of service. If I obtain or wish to use health insurance, I agree to notify the Practice immediately. I understand that at that time, the Practice will be happy to add that information and bill my insurance company for services provided from the date of notification and forward. I understand that the Practice cannot *back bill* the insurance company for services previously rendered.

Payment Options if you have *no insurance*:

You may choose to pay by cash, check, money order or credit card. Payment is due at the time of service. Financing for services should be established by securing a loan through a third party lender.

Patient/Guardian Signature _____ **Date** _____

IF SEEN BY A CLINICIAN REQUIRING SUPERVISION

I understand that I am seeing a counselor-in-training who is under the supervision of _____ and will share aspects of my therapy and relevant personal information as part of my supervision. If at any point I desire a direct consult with the supervising clinician, I understand that this will be arranged by my clinician.

Patient/Guardian Signature _____ **Date** _____

PATIENT STATEMENTS

Payment is required at the time of service. Any outstanding balances will be billed directly to the patient. These charges must be paid within 10 days of receipt of the statement. Billing fees are added immediately while finance charges begin to accrue after 30 days. A rebilling fee may be added every 30 days for accounts not paid in full. If a payment agreement has been established, we have the right to cancel this agreement at any time with notice. Future visits would then need to be paid at the time of service.

INSURANCE

Insurance is a contract between you and your Insurance Company. We are not a party to this contract in most cases. We will bill your insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You are responsible and agree to pay for any charges not covered by your insurance company. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to do so may result in a denial or a lower reimbursement from the insurance company.

RETURNED CHECKS

There is a fee of \$55.00 for administrative fee for all checks returned by the bank. This fee and the charges must be paid within **10 days** by cash, cashier's check or money order. Please remember that it is against the law to write checks without sufficient funds.

MISSED AND LATE APPOINTMENTS

Patients who do not show up for an appointments or who cancel their appointment with less than 24-business hours notice will be charged a fee. This fee must be paid before a new appointment is scheduled. Patient with multiple misses or late cancellations may be asked to transfer their care to another office.

PAST DUE ACCOUNTS

If your account becomes past due we will take necessary steps to collect the debt. If we have to refer your account to a collection firm or attorney, you agree to pay all of the incurred collection costs, including but not limited to fees and court costs. You understand that if the account is turned over for collection, the fact that you received treatment may become a matter of public record.

DIVORCE

In the case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce, the parent/guardian authorizing treatment becomes the parent/guardian responsible for all subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's/guardian's responsibility to collect from the other parent. Please remember that both parents retain the right to medical information of a minor child unless specifically prohibited by the courts.

FORMS AND LETTERS

Request for completion of forms or the need for a written document must be submitted directly to the clinician. Authorization must be specific to the information you request sent. On average, forms require a minimum of five business days for completion and requests for letters require a minimum of ten business days. If a fee is indicated, charges are established at the time by the clinician and must be paid before the form/letter is released. These fees are not reimbursed by insurance companies. Written authorization is required.

MEDICAL RECORDS

We require a written release to transfer records to another doctor or organization. Authorization must be specific to the information you request sent. If a fee is required for transfer of records, this fee must be paid prior to the release of the records.

EMERGENCY CALLS

We are available for emergencies outside of regularly scheduled appointments and office hours. We request routine calls be made during the regular business day. If the context of an emergency call becomes one of treatment rather than handling an emergency situation, a fee may be applied to that contact. This fee is usually not covered by your insurance company and must be paid prior to your next visit.

Patient/Guardian Signature _____ **Date** _____

Diane Eden MD & Associates, Inc.

Patient Rights

- Receive respectful treatment that will be helpful for you
- Receive a particular type of treatment or end treatment without obligation to harassment
- A safe environment, free from sexual, physical or emotional abuse
- Report unethical or illegal behavior by a clinician
- Ask questions about your treatment
- Request and receive full information about the credentials of your clinician
- Request and receive complete information about fees, methods of payment, insurance reimbursement, and cancellation policies
- Refuse electronic recordings, or may request this if you wish
- Be educated on the limits of confidentiality and the circumstances under which a clinician is legally required to disclose information about you to others
- Know whether there are supervisors or others with whom your clinician will discuss your case and treatment
- Request and receive a summary of your clinical file including your diagnosis, progress and type of treatment
- Request the transfer of a copy of your clinical file to any clinician or agency you choose
- Receive a second opinion of your diagnosis and treatment at any time you choose
- Request that your clinician inform you of your progress and treatment plan
- Receive a copy of this form

Patient Name (printed)_____Date_____

Patient/Legal Guardian_____

Witness _____

Diane Eden MD & Associates, Inc.

Privacy Rights

Diane Eden MD & Associates Inc respects your privacy and only discloses your medical information when necessary or appropriate. Our Notice of Privacy Practices describes potential uses and disclosures of your health information by our practice and outlines your privacy rights as a behavioral health patient.

Any questions regarding this Notice of Privacy Practices may be directed to your clinician or to our Privacy Compliance Officer at 440-951-5600.

Your signature on this form indicates that you understand your privacy rights and have received a copy of our Notice of Privacy Practices if you have requested one.

Patient Name (Printed) _____ Date _____

Patient/Legal Guardian _____

Witness _____

Patient Health Form

Patient Name _____ **Completed by** _____

Reason for Seeking Treatment _____

How are your problems affecting you on a day to day basis? How long have you had these problems? _____

Medical History

Medication Allergies: No ___ Yes (list) _____

Ongoing Medical Conditions: _____

Current Medications- Rx and OTC (name, dose & frequency) _____

If **female**, are you currently pregnant? Yes ___ No ___ Birth Control? No ___ Yes ___ Type _____

Primary Care Physician (name/address) _____

OK to Communicate: Yes ___ No ___ **Referred by:** _____

Educational History: Highest Level of Education _____ Classes: Regular ___ Special _____

Past Psychiatric Treatment

Previous Counseling: No ___ Yes ___ Who/When _____

Previous Psychiatric Rx: No ___ Yes ___ Who/When _____

Previous Psych. Hospitalization: No ___ Yes ___ When/Where/Why _____

Previous Chemical Dependency Rx: No ___ Yes ___ When/Where/Why _____

Previous Suicidal Thinking/Attempt: Yes ___ No ___ Previous Homicidal Thinking/Action: Yes ___ No ___

Describe **Yes** Response _____

Past Psych. Meds (names/doses/duration) _____

Habits:	Current Use	Past Use
Caffeine	_____	_____
Tobacco	_____	_____
Alcohol (type/amount)	_____	_____
Drugs (type/amount)	_____	_____

REVIEW OF SYMPTOMS

Do you now or have you ever had a problem with drugs or alcohol? Yes ___ No ___

Do you now or have you ever had a problem with gambling or any other addiction? Yes ___ No ___

Do you now or have you ever had symptoms of an eating disorder? Yes ___ No ___

Do you now or have you ever had a problem with obsessions, rituals or hoarding items? Yes ___ No ___

Do you now or have you ever had problems in social situations? Yes ___ No ___

Do you now or have you ever had problems with anxiety or panic or fears (phobias)? Yes ___ No ___

Do you now or have you ever had problems with attention, concentration or focus? Yes ___ No ___

Do you now or have you ever had problems with impulse control? Yes ___ No ___

Do you now or have you ever had problems with excessive spending or racing thoughts? Yes ___ No ___

Do you now or have you ever had problems with hallucinations or paranoia? Yes ___ No ___

Do you now or have you ever had problems with sadness or loss of interest or pleasure? Yes ___ No ___

Do you now or have you ever had problems with the law or been involved in the legal system? Yes ___ No ___

Are you now or have you ever been the victim of abuse or a violent crime? Yes ___ No ___

Are you now or have you ever served in the US Armed Forces? Yes ___ No ___ **Honorable D/C** Yes ___ No ___

If yes to any of the above, please explain: _____