

EVANSVILLE PSYCHIATRIC ASSOCIATES

PATIENT INFORMATION / REGISTRATION:

Patient Name: _____ Social Security Number: _____ - _____ - _____
Sex: [] Male [] Female Birth Date: _____ Age: _____ [] Married [] Divorced [] Single [] Widowed
Home Address: _____
Street City State Zip Code
Home Telephone: _____ Cell Phone: _____ Work Phone: _____ Ext. _____
Primary Care Physician: _____ Phone: _____
Patient's Employer: (if applicable) _____
Relative's Name: _____ Phone: _____
Relative's Address: _____ Relationship: _____

This section for: [] Spouse Information or [] Parent's Information (For parent information, fill in both sections completely)

Name: _____ Name: _____
Address: _____ Address: _____
City/State/Zip: _____ City/State/Zip: _____
Home #: _____ Work #: _____ Home #: _____ Work #: _____
SSN#: _____ Birth date: _____ SSN#: _____ Birth date: _____
Employer: _____ Employer: _____
Employer Address: _____ Employer Address: _____
Employer Phone: _____ Employer Phone: _____

Primary Insurance: _____ Secondary Insurance: _____
Insured Name: _____ Insured Name: _____
Insured Date of Birth: _____ Insured Date of Birth: _____
Policy Number: _____ Policy Number: _____
Group Number: _____ Group Number: _____
Social Security Number: _____ Social Security Number: _____

If patient is a minor: Please complete appropriate questions: Are both parents living? [] Yes [] No.
If no, is there a legal guardian? [] Yes [] No Please explain: _____
Is this a foster situation? [] Yes [] No. Where does this child live? _____
Parents are: [] Married [] Living Together [] Separated [] Divorced. If parents divorced, is there joint custody? [] Yes [] No
If parents live apart who is the custodial parent? _____ Which parent is responsible for medical decisions? _____
Who is the person responsible for covering health care expenses? _____

I hereby authorize Evansville Psychiatric Associates to use my signature to process my insurance or Medicare/Medicaid claims as necessary and send whatever medical records are needed to process insurance claims by my insurance company.

Patient/Parent/Guardian/Legal Representative Signature* Date _____

*Guardian/Legal Representative must provide this office with legal documentation of this relationship.

EVANSVILLE PSYCHIATRIC ASSOCIATES*Complete Outpatient Mental Health Care*

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 Evansville, Indiana 47711
 (812) 422-7974

www.evansvillepsychiatric.com

AGREEMENT TO PAY / AUTHORIZATION FOR INSURANCE PAYMENT

I agree to pay for all fees or my portion not covered by medical insurance **at the time of service**. Payments are expected on the date of service. Co-payments and deductibles not made on the date of service may be charged an additional fee of \$10.00. I realize I am also responsible for full payment of fees, not paid by insurance, within 30 days of notification by Evansville Psychiatric Associates. I agree to be responsible for any fees required to collect payment for services including: attorney and court costs, collection agency fees, pre-judgment and/or post-judgment interest at the current legally allowed rate.

Postage and handling charges for any mailings will be added to my account at the current clinic rate. There are additional charges if we are legally required to send letters Certified or Registered. If appointments are missed and prescriptions or mailings are required, a medication refill charge will be added to my account at the current clinic rate. Our clinic offers a pre-paid annual prescription mailing program to specific clients that demonstrate good adherence to treatment recommendations and if this is offered, this must be paid before mailings will be included in this program.

No finance charge will be added for up to 29 days while any insurance is pending. No finance charge will be imposed upon any balance that is paid within 29 days of the billing date. Any overpayment will be refunded within 30 days of notification. After such date the finance charge is computed at a single monthly periodic rate of 1.5% per month, an annual percentage rate of 18%, or a minimum finance charge of \$0.50, and applied to the adjusted balance. The adjusted balance is computed on the previous balance, after adjustment for payments, credits or charges, including finance charges or other charges related to missed appointments.

The entire balance, together with finance charges, will be immediately due and owing, and shall be collectible by legal process. I understand that if any unpaid balance is assigned to a third party collection agency for collection or placed with an attorney to obtain judgment or otherwise satisfy payment of my account, a collection fee of 33% will be added to my account. I agree to pay that fee. I further agree to pay reasonable attorney fees and court costs. I understand and agree to the above terms.

Checks returned for NSF are subject to a \$25.00 fee. For balances that must be billed there will be a statement fee of up to \$1.50 per statement sent.

I hereby authorize my insurance company to make payment directly to Evansville Psychiatric Associates for all appointments and charges made at Evansville Psychiatric Associates, unless I pay in full at the time of service. I understand that medical records may need to be released to my insurance company in order to substantiate claims. If needed, my signature may remain on file for use to file Medicare claims that I am responsible for.

AND MISSED APPOINTMENT / LATE FOR APPOINTMENT / LATE CANCELLATION POLICY

We encourage our patients to keep and be on time for their appointments. Our clinicians stay on time for their appointments barring medical emergencies. If you are late for your appointment, your clinician may not be able to see you and you may have to reschedule. Appointment times are scheduled specifically for you and we do not operate as some traditional doctor's offices or overbook our appointments. We have implemented fees for missed appointments and late cancellations. Patients may be charged between \$25.00 and \$100.00 for a missed appointment, or for the failure to cancel at least twenty-four (24) hours prior to the appointment depending on the type of appointment scheduled, e.g., testing, evaluations, therapy, Medical Management. New patient appointments are required to leave a deposit for their reserved time that is only charged if this appointment is missed. The fee is based upon the type of appointment scheduled and the specific clinician you are scheduled to see and whether this is clearly an unusual circumstance for you.

I have read and understand and agree to these policies.

 Patient/Parent/Guardian/Legal Representative (Responsible Party)

 Date