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SOUTHAMPTON

psychiatricassociates

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____

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

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

Last Tetanus Shot? __________

Pneumovax Shot? __________

Flu Shot? __________

Hepatitis B Vaccine? __________

OTHER VACINES YEAR

Lyme Vaccine? __________

Hepatitis A Vaccine? __________

SCREENING TESTS (LAST ONE) YEAR

Mammogram? __________

Pap Smear? __________

Stool check for blood? __________

YEAR

Breast exam? __________

Cholesterol Check? __________

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

Do you wear a bike helmet? ☐Yes ☐No

Do you smoke? Amount: ____________ ☐Yes ☐No

Do you drink alcohol beverages? ☐Yes ☐No

Do you drink coffee? Amount:________ ☐Yes ☐No

Do you drink tea? ☐Yes ☐No

Is there a gun in your home? ☐Yes ☐No

Do you use drugs? Type:_____________ ☐Yes ☐No

Women: Do you perform self breast exams? ☐Yes ☐No

Men: Do you perform self testicular exams? ☐Yes ☐No

Do you exercise regularly? ☐Yes ☐No

Are you following a specific diet? ☐Yes ☐No

If so, type of diet: ________________________________

Do you ever feel afraid of your partner? ☐Yes ☐No

Do you have a living will? ☐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 **$50 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 8/1/2024

PSYCHIATRY

Evaluation	$290
45 minute session	$235
20/30 minute session	$200
Brief medication session	$105

PSYCHOLOGY

Evaluation	$225
Full therapy session	$185-$195
Group session	$55

LICENSED PROFESSIONAL COUNSELORS/SOCIAL WORKER

Evaluation	$175
Full therapy session	$155-$165
Group session	$50

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.