PATIENT INFORMATION

First Name_____ M.I____ Last Name_____

Address_____

City/State/Zip_____ SSN.#_____

Marital Status: S M D W Sex: M F Date of Birth_____/_____/_____ Age _____

Primary Phone_____ Secondary Phone_____

Employer_____ Email_____

PARENT/GUARDIAN

Name_____ Date of Birth_____/_____/_____

Employer Name_____SSN.#_____

Address (if different) _____

Home Phone_____ Work Phone_____ Cell Phone_____

Relationship to Patient_____

INSURED OR RESPONSIBLE PARTY (POLICY HOLDER) INSURANCE INFORMATION

Policy Holder Name_____ Relationship to Patient_____

Insurance Company_____ Member ID_____ Group Number_____

Effective Date _____ SSN#_____ DOB_____/____/____

The phone number(s) listed above authorizes CMPS to leave messages containing patient information

Referring Physician Name/Phone #: _____

Signature of Patient/Guardian:_____Date:_____

RELEASE OF INFORMATION

Patient Name: _____ Date of Birth: _____

SSN:_____ Contact Phone Number: _____

I authorize the custodian of records of: Coastal Medical and Psychiatric Services Inc.

This release is to: [ ] Be kept on file

1. Name: _____ Medical / Billing

Relationship: _____Phone Number: _____

2. Name: _____ Medical / Billing

Relationship: _____Phone Number: _____

3. Name: _____ Medical / Billing

Relationship: _____Phone Number: _____

4. Name: _____ Medical / Billing

Relationship: _____Phone Number: _____

Please Indicate below the information you would like disclosed

_____ Care and condition
_____ Test Results
_____ Psychological/Mental Health/Psychiatric Information
_____ Pick Up Prescriptions
_____ Pick Up Samples
_____ Pick Up Forms
_____Make/Cancel Appointments

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is by my request to release my medical records to the entity or facility listed above. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information. I understand that by signing this release form, if I have requested a copy of my medical records previously, that there may be a charge for an additional copy.

Signature: _____ Date: _____

PATIENT HEALTH HISTORY

Patient Name: _____ Date of Birth: _____

1. Yes	No	Is your general health good?			
2. Yes	No	Has there been changes in your health in the last year?			
3. Yes	No	Have you been hospitalized for a serious injury in the last year?			
		If YES, why? _____			
4. Yes	No	Are you being treated by a physician now?			
5. Yes	No	Are you in Pain currently?			
6. Yes	No	Chest Pain	16. Yes	No	Dizziness
7. Yes	No	Swollen Ankles	17. Yes	No	Ringing in Ears
8. Yes	No	Recent weight loss, fever, night sweats	18. Yes	No	Headaches
9. Yes	No	Persistent cough	19. Yes	No	Seizures
10. Yes	No	Bleeding problems, bruising easily	20. Yes	No	Fainting Spells
11. Yes	No	Sinus Problems	21. Yes	No	Blurred Vision
12. Yes	No	Difficulty Swallowing	22. Yes	No	Excessive Thirst
13. Yes	No	Diarrhea, constipation, blood in stool	23. Yes	No	Frequent Urination
14. Yes	No	Frequent vomiting or nausea	24. Yes	No	Dry Mouth
15. Yes	No	Difficulty Urinating, blood in Urine	25. Yes	No	Joint or Muscle Pain
26. Yes	No	Heart Disease	37. Yes	No	AIDS
27. Yes	No	Heart attack, heart defects	38. Yes	No	Tumors or Cancer
28. Yes	No	Heart murmurs	39. Yes	No	Arthritis
29. Yes	No	Rheumatic fever	40. Yes	No	Eye Disease
30. Yes	No	Stroke, hardening of arteries	41. Yes	No	Skin Disease
31. Yes	No	High blood pressure	42. Yes	No	Anemia
32. Yes	No	Asthma	43. Yes	No	Herpes
33. Yes	No	Hepatitis or other liver disease	44. Yes	No	Kidney or Bladder disease
34. Yes	No	Stomach problems or Ulcers	45. Yes	No	Thyroid Disease
35. Yes	No	Allergies to drugs, food, or medication	46. Yes	No	STD
36. Yes	No	Family history of diabetes, heart problems	47. Yes	No	Diabetes
48. Yes	No	Psychiatric care	53. Yes	No	Hospitalization
49. Yes	No	Radiation Treatments	54. Yes	No	Blood Transfusion
50. Yes	No	Chemotherapy	55. Yes	No	Surgeries
51. Yes	No	Prosthetic Heart Valve	56. Yes	No	Pacemaker
52. Yes	No	Artificial Joint	57. Yes	No	Any Valves
58. Yes	No	Recreational Drugs	60. Yes	No	Tobacco
59. Yes	No	Medication Drugs including over the counter	61. Yes	No	Alcohol

Please List: _____

62. Yes	No	Are you or could you be pregnant or nursing?	63. Yes	No	Using birth control
64. Yes	No	Do you or have you had any medical problems NOT listed on this form?			

If so, please explain: _____

To the best of my knowledge, I have answered each question completely and accurately. I will inform my provider of any change in my health and/or medications.

Signature: _____ Date:_____

FINANCIAL POLICY

Payments and copays for all services will be due at the time services are rendered. In order to serve you better we accept cash, Visa, MasterCard, and Discover. As a courtesy to you, it is the policy of CMPS to bill your insurance carrier, although you are ultimately responsible for the entire bill. As the responsible party, please understand:

PLEASE READ AND INITIAL THE FOLLOWING:

_____1. Your insurance policy is a contract between you, your employer, and your insurance company. We are not a party to that contract. Our relationship is with you, not your insurance company. We will not become involved in disputes between you and your insurance regarding deductibles, co-payments, secondary insurance and "usual and customary" charges. As your medical provider, we will only supply factual information to facilitate claim processing.

_____2. Fees for services, which include unpaid balances, deductibles and co-payments are due at the time of service. If these balances are not paid in a timely manner, we have the right to cancel your appointment until you have paid a majority of the remaining balance. Returned checks and unpaid balances may be subject to collection placement and collection fees. The office will mail at least one statement. If payment is not received by statement due date your account will be considered delinquent. Delinquent accounts will receive notice of delinquency followed by a final notice. Failure to make payment may result in further legal actions.

_____3. I accept responsibility for payment of all treatment that the payer (insurance) determines does not constitute covered services, court costs and any other costs of collection should such action become necessary. Collection costs may include an attorney fee of up to 33.1/3%, a returned check fee of $62.00, and interest on delinquent balance should such action become necessary.

_____4. **I UNDERSTAND THAT I WILL BE CHARGED FOR ANY APPOINTMENTS NOT KEPT UNLESS 24 HOURS NOTICE IS GIVEN TO THE OFFICE.** No Show fees are $55.00, and the Late Cancellation is $37.50 and my insurance will not cover that charge. The law does not allow CMPS to bill insurance companies for missed appointments; therefore, I, the patient, am fully responsible for these fees.

_____5. All charges are your responsibility whether you're insurance company pays or does not pay. If any payment is made directly to you for services billed by CPMS, you recognize an obligation to promptly remit payment to CMPS.

_____6. You understand and agree that if you fail to make any of the payments for which you are responsible in a timely manner, after such a default and upon referral to our collection agency or attorney by CMPS, you will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

At CMPS, we understand that financial problems may affect timely payment, so we encourage you to communicate any such problems to us, so that we may assist you in keeping your account in good standing. If you have any questions, please call our billing department at 757-223-2939.

I UNDERSTAND THE ABOVE INFORMATION AND WILL BE RESPONSIBLE FOR THE PATIENT LISTED BELOW:

Printed Name of Patient: _____ Date: _____

Signature of Responsible Party: _____ Date: _____

Subpoena Contract

This contract is an agreement between the interested parties that no party shall attempt to subpoena my testimony or my records for a deposition or court hearing of any kind for any reason.

All parties acknowledge that the goal of psychiatric treatment is the improvement of psychological/mental distress and interpersonal conflict, and that the process of treatment depends on trust and openness during the sessions.

Therefore it is understood by all parties that if they request my services as a psychotherapist, play therapist, or prescriber, they are expected not to use the information given to me during the therapy process for their own legal purposes or against any of the other parties in a court or judicial setting of any kind.

_____ _____
Printed name Relationship to client

_____ _____
Signature Date

_____ _____
Printed name Relationship to client

_____ _____
Signature Date

_____ _____
Printed name Relationship to client

_____ _____
Signature Date

_____ _____
Printed name Relationship to client

_____ _____
Signature Date

Acknowledgment of Receipt

I hereby acknowledge that I have received a copy of the Privacy Practices of CMPS, Inc.

Patients Name: _____

Patient Signature: _____

Date: _____

If you are signing as the personal representative of the patient:

Personal Representatives Name: _____

_____ ***Please initial that you have received a copy of the CMPS Welcome Pamphlet.***

_____

(Office Use Only)

Personal Representatives Signature: _____

Relationship to the patient: _____

CMPS, attempted to obtain written acknowledgment of receipt of the Notice of Privacy Practices, but acknowledgment could not be obtained because:

[ ] Individual refused to sign

[ ] An emergency situation prevented us from obtaining acknowledgment

[ ] Other (Please specify below)

_____

Employee Signature: _____

Date: _____