PSYCHIATRIC MEDICINE ASSOCIATES

1505 Westlake Ave. N, Suite 920
Seattle, WA 98109-6211

T (206)386-3103 **F** (206)386-3123
www.psychiatricmedicine.com

NEW PATIENT REGISTRATION

GENERAL INFORMATION

Name: _____ DOB: _____ Sex: _____

Mailing Address: _____

City, State, ZIP: _____

SSN: _____ Employer: _____

Preferred Telephone: _____ May we leave a message? Yes ☐ No ☐

Secondary Telephone: _____ May we leave a message? Yes ☐ No ☐

E-mail: _____ May we send a message? Yes ☐ No ☐

EMERGENCY CONTACT

Full name and Relationship to you: _____

Home Telephone: _____

Work Telephone: _____

Cellular Telephone: _____

REFERRING PROVIDER

Who referred you to PMA? _____

Please fill out a separate release form (attached) for each person you would like us to coordinate care with.

CONSENT FOR CARE

I, the patient or patient's legal representative, hereby grant permission to Psychiatric Medicine Associates to perform such examinations, medical, and therapeutic procedures as may be professionally deemed necessary or advisable and to communicate about them via telephone, mail, facsimile, and e-mail for my diagnosis, treatment, payment, and healthcare operations.

I am aware that the practice of medicine is not an exact science and that no guarantees or promises have been made to me as to the result of treatment or examination.

Patient Signature: _____ **Date:** _____

Patient Printed Name: _____

PSYCHIATRIC MEDICINE ASSOCIATES

1505 Westlake Ave. N, Suite 920
Seattle, WA 98109-6211

T (206)386-3103 **F** (206)386-3123
www.psychiatricmedicine.com

ASSIGNMENT OF BENEFITS & AUTHORIZATION TO RELEASE PATIENT HEALTH INFORMATION FOR TREATMENT, BILLING, OR HEALTHCARE OPERATIONS

You are not required to give this authorization. However, claim charges denied due to a failure to provide requested documents (due to a lack of authorization) will be the responsibility of the patient.

I hereby assign to Psychiatric Medicine Associates the insurance benefits that may be payable to me for services provided, arising from any policy of insurance, self-insured health plan, in my name or on my behalf. I further authorize payment of benefits directly to Psychiatric Medicine Associates. I understand that I am responsible for satisfying the pre-certification requirements for any policy of insurance, self-insured health plan, or government plan covering services provided by Psychiatric Medicine Associates.

I understand that acceptance of insurance assignment does not relieve me from any responsibility concerning payment for medical services and that I am financially responsible for all charges whether or not they are covered by my health insurance. **Late Cancellations and Appointment No Shows have a $125 fee which insurances will not cover**.

I understand that I have the right to review the Privacy Notification prior to signing this consent. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations. I understand that I may revoke this consent in writing, except to the extent that Psychiatric Medicine Associates and support staff have already taken action in reliance thereon. I also understand that Psychiatric Medicine Associates and their support staff are not required to adhere to the restrictions requested in the event of a potentially life-threatening emergency.

Records may be needed in order to process a claim for medical services. I authorize Psychiatric Medicine Associates to release information needed for billing purposes to entities that may provide services pertaining to my physician visit, such as reference laboratories. I understand that by signing below, I am authorizing the release of all or part of my medical record for the purpose of my treatment, billing, or pertinent healthcare operations. This release may include records containing information regarding the diagnosis and/or treatment of HIV or AIDS, mental illness, and/or drug and/or alcohol addiction or abuse to any person or corporation which is or may be liable under contract for all or part of the medical charges.

Patient Signature: _____ **Date:** _____

Patient Printed Name: _____

Check mark the box to receive electronic statements via Patient Portal ☐

PSYCHIATRIC MEDICINE ASSOCIATES

1505 Westlake Ave. N, Suite 920
Seattle, WA 98109-6211

T (206)386-3103 F (206)386-3123
www.psychiatricmedicine.com

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF OFFICE POLICIES AND PROCEDURES

I have received a copy of Psychiatric Medicine Associates' Notice of Office Policies and Procedures. I understand and agree to abide by them and consent to receive treatment.

I understand and agree to abide by the late cancellation and missed appointment policy which **requires a full business day (24 hours) notice or will incur a $125 fee**. Monday morning appointments need to be cancelled by Friday morning.

Patient Signature: _____ **Date:** _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND POLICIES

In order to comply with HIPAA standards, each practice must obtain a signed acknowledgement that each direct treatment patient has received its Notice of Privacy Practices and Policies or must document a good faith effort to provide the Notice and receive a written acknowledgement of receipt. This will allow practices to use or disclose confidential information (protected health information) for treatment, payment, or healthcare operations.

I have received a copy of the Notice of Privacy Practices and Policies from:

Psychiatric Medicine Associates
1505 Westlake Ave. N, Suite 920
Seattle, WA 98109-6211

Patient Signature: _____ **Date:** _____