NORTHERN MICHIGAN PSYCHIATRIC SERVICES, P.C.

2022 PATIENT INFORMATION SHEET

Patient Name: _____ Date Of Birth: _____ Male or Female

Address: _____City: _____ Zip Code: _____

Home Phone: _____ Patient's Cell #: _____

Marital Status: Single Married Divorced Widow

Spouse/Significant other's Name: _____

Cell #: _____

Email _____ Reminders: Text # _____

Do you consent to: text messages? Y – N emails? Y – N

Emergency Contact Person: _____ Phone: _____

Relationship to Patient: _____

Language: _____ Race: _____ Ethnicity: _____

FINANCIAL RESPONSIBLE PARTY INFORMATION:

Name: _____ Relationship to Patient: _____

Address: _____

Cell #: _____ Employer: _____

INSURANCE INFORMATION:

Insurance Company: _____ Subscriber's Name: _____ DOB:_____

Group #: _____ Enrollee ID #: _____

Preferred Pharmacy Name: _____ Phone #: _____

(PLEASE TURN OVER - SIGNATURE IS REQUIRED)

Limits of Confidentiality, Medication and Review of Financial Policies

Limits of Confidentiality:

By signing below, you are authorizing the release of any medical information necessary to process your insurance claim. This includes a release to Athena Net, or other agents of Northern Michigan Psychiatric Services P.C.

Medication Polices:

Please be aware that in order to provide appropriate care Northern Michigan Psychiatric Services PC does NOT make changes in medication except during appointments with your provider.

Financial Policies:

1. It is our policy that full payment is made at the time of service. Meet with the receptionist at the time of service to pay your account in full.
2. Your insurance is a method for you to possibly receive some reimbursement for fees you have paid for services provided. Having insurance is not a substitute for payment. It is your responsibility to determine which services and service providers may be covered by your insurance. **Past due balances (over 60 days) will be assessed 2% interest per month.**
3. Because individual time is set aside specifically for you by your physician/clinician, the full charge must be levied for appointments not cancelled **at least 24 business hours in advance**. Missed appointment charges cannot be billed to any insurance company and the **full fee will remain the patient's responsibility**.
4. The responsible party's **failure to keep up with his/her financial obligations is cause for termination of services**.
5. We will be happy to assist you in filing claims with most primary insurance company, except Medicare/Medicaid and BCN.
6. Northern Michigan Psychiatric Services, P.C., cannot assume responsibility for accuracy in estimation of insurance benefits or for success in collecting insurance claims, nor will it change its fees, services, or diagnosis to meet the demands of your insurance company.
7. There is a charge for all Requests for copies of medical records.
8. For completion of forms or letters you will be charged your clinicians hourly rate. Please ask your provider about this. An office visit may be required for completion of forms.
9. If there is no payment for 90 days, your account will be reviewed with a potential of going to the collection agency; if your account is sent to the collection agency a percentage of your existing balance will be added to your account to cover cost of the collection agency.
10. Any Patient who has a check returned unpaid from the bank to Northern Michigan Psychiatric Services, P.C., will be assessed a $25.00 handling fee.
11. Forensic services, such as evaluations for custody and visitation recommendations, must be arranged in advance as such, are not usually covered by insurance, have a different fee structure, and must be paid in advance. Forensic services are generally not provided by Northern Michigan Psychiatric Services, P.C.
12. **Regardless of your insurance status, you are ultimately responsible for the balance of your account for all professional services rendered.**
13. These policies may change at any time without notice.

I have read the above statements, understand the Limits of Confidentiality, and agree to abide by the Financial Policies of Northern Michigan Psychiatric Services, P.C.

Signature of Patient: _____ Date: _____

Signature of Parent/Legal Guardian: _____ Date: _____
(If appropriate)