# Walk-In Appointments Office Procedure

## (NEW PATIENTS ONLY)

Psychiatric Services is the **only** mental health practice in the area which offers same-day walk-in appointments for **NEW** patients.
(Please be advised that this service is **ONLY** available for **NEW PATIENTS.)**
All follow-up appointments must be scheduled.

**Once the new patient packet is complete:**

1. We will enter your information into our system.
2. We will contact your insurance company to obtain information regarding your benefits.
3. We will collect any deductibles, co-pays, or co-insurance prior to services.
4. We will assign you an appointment time, but please be aware that you may be given an appointment later in the day or possibly another day. We assign time slots on a first-come-first-serve basis, and only a limited number of new patient slots are available at any given time.
5. A urine drug screen may be requested prior to your appointment.

Every effort will be made to give you a same-day appointment, but we cannot guarantee availability.

We look forward to serving you and your family's needs.

We are here when you need us most!

Thanks,

**The Team at Psychiatric Services FW PC**

**Psychiatric Services FW PC**
**7806 West Jefferson Blvd, Suite C, Fort Wayne, IN 46804**
**Tel: 260-203-4188 Fax: 260-203-5136**
**Email: contact@ psychiatricservicesfwpc.com**
**Website: www.psychiatricservicesfwpc.com/**

Psychiatric Services FW PC

## Patient Registration Form

**(All information is confidential)**

First Name:________________________________Last Name: ________________________________

Home Address: ________________________________ City, State, Zip: ________________________

Home Phone: ________________________________ Cell Phone: _____________________________

SSN (Last four digits only): XXX-XX-______ Birth Date: ______________ Age: ____ Sex: ________

Race: ______________ Marital Status: ________N/A #Children: ________N/A Ages: ________N/A

Employer: _____________________________ Work Telephone:______________________________

Primary Insurance: _________________________ Number: ___________________________________

Secondary Insurance: _________________________Number:___________________________________

Pharmacy Preferred: __________________________________________Zip:_____________________

Emergency Contact: ________________________________ Relationship to Patient: ________________

Address: ________________________________ City, State, Zip: ______________________________

Home Number: _________________ Cell Number:______________Work Number:_________________

Family Physician: __________________________________ Email: ____________________________

Address: ________________________________ City, State, Zip: ______________________________

Office Number: _______________________________ Fax:___________________________________

Your Email(For Web Portal) ____________________________________________________________

___________________________________________________

Signature of Patient / Authorized Caregiver (If patient is under 18 years old) Date

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# Psychiatric Services FW PC

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**Psychiatric Services FW PC**

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# Treatment Consent

I do hereby acknowledge that I am requesting treatment from the providers at Psychiatric Services FW PC. If I am bringing a patient to Psychiatric Services, I do hereby give my consent and permission to Psychiatric Services to administer treatment to the patient and I attest that I have legal rights to request and administer such treatment.

I understand that the physician may order specific medical procedures as part of the treatment. I am aware that I may stop treatment at any time. I am aware that an agent of my insurance company or other third-party payer, may be given information regarding cost, date(s) and/or types of services received. I am aware of my right to have a copy of this statement. I consent that I am responsible for verifying with the insurance company that treatment is covered. In the event the insurance claim is denied, I will be held liable and will pay any outstanding balances to Psychiatric Services FW PC.

I consent to this office using any electronic or non-electronic means (including online databases) to obtain prescription history so that the best clinical decisions can be made regarding treatment. I consent to both birth parents having access to records. I consent that Psychiatric Services FW PC sends/allows the Primary Care Provider (PCP) and therapist access to medical records. I understand and consent to be treated by providers who may include therapists and physicians.

I consent to working with psychological assistants for a portion of the process if I receive psychological testing. I understand that if I do not come to my appointment to discuss the test results, a regular therapy appointment will be made to discuss these results and to receive therapy. I consent to not using my phone in the providers office for any reason and consent to bringing my medication bottles to every appointment or run the risk of not being seen. I will also ensure that I will not leave any children unattended while at the office.

I understand that many medications may adversely affect pregnant women and unborn children. I consent that if I am currently not using contraceptives, intend to get pregnant or am currently pregnant, I must inform the provider immediately. I consent that if I (or any patient in my care) relocate, Psychiatric Services FW PC will not prescribe medication if unable to find a new provider. I understand that it is recommended to schedule my last appointment three day prior to relocating to ensure I have at least 30 days of medication.

I consent to the following: The first visit does not automatically mean/imply that Psychiatric Services FW PC providers are assuming the responsibility of psychiatrist. We use the first visit for assessment only. If we determine that we are not able to make rapport or we determine that we are not able to help, we will refer you to other providers in the community who can. If progress is not being made, if treatment recommendations are not being followed or for any reason whatsoever, I consent to being referred to another provider/office at any time.

I understand that Psychiatric Services FW PC does NOT have a physician/telephone operator available on-call 24 hours a day,7 days a week. I consent and understand that telephone calls may be handled by an answering machine and I may need to leave a voicemail. It may take up to 48 hours to receive a call back. I understand that I need to call 911 or go to the nearest emergency room if I (or the patient I am taking care of) experience suicidal thoughts, homicidal thoughts, side effects from medication, or any other crisis.

________________________________________

Name of Patient / Authorized Caregiver (If patient is under 18 years old)

________________________________________

Signature of Patient / Authorized Caregiver (If patient is under 18 years old) Date

## Authorization To Be Photographed

I agree to be photographed by a staff member of Psychiatric Services FW PC. I understand that this photograph will be attached to my active medical record and will be used for identification purposes only. I also understand that Psychiatric Services FW PC will ensure and promote the strictest standards of confidentiality, and that upon my discharge/completion of the treatment program, this photograph will be retired along with any active records and become a permanent addition to my medical records.

________________________________________________

Name of Patient / Authorized Caregiver (If patient is under 18 years old)

________________________________________________

Signature of Patient / Authorized Caregiver (If patient is under 18 years old) Date

## Phone Availability Consent

I understand that Psychiatric Services FW PC does NOT have a physician/telephone operator available on call, 24 hours a day, 7 days a week. I consent and understand that telephone calls may be handled by an answering machine and I may need to leave a voicemail. It may take up to 48 hours to get a call back. I understand that I need to call 911 or go to the nearest emergency room immediately in the event of an emergency. I understand that I need to call 911 or go to the nearest emergency room immediately if I (or the patient in my care) experience suicidal thoughts, homicidal thoughts, side effects from medication, or any other crisis.

If I am the parent or guardian of a patient at Psychiatric Services FW PC, I understand that at the first sign of danger, suicidal or homicidal behavior, thoughts, ideas, plan, or action, I must call 911.

Alternatively, I also consent to receiving voicemails, with any information as it relates to my care (or the patient in my care), from the telephone numbers I have provided to Psychiatric Services FW PC.

________________________________________________

Name of Patient / Authorized Caregiver (If patient is under 18 years old)

________________________________________________

Signature of Patient / Authorized Caregiver (If patient is under 18 years old) Date

# Financial Policy Consent

**Patients of Psychiatric Services FW PC and their caregivers are responsible for:**

1. Payment before services is rendered.
2. Verifying that their insurance is active and covers mental health benefits.
3. Verifying that the providers at Psychiatric Services are in-network.
4. Any outstanding payments.
5. Working with a third-party collection agency in case of non-payment.

**Cancellation of an Appointment:**
In order to be respectful of the medical needs of other patients, please be courteous and call the office promptly if you are unable to attend an appointment. This time will be reallocated to someone who needs treatment. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance. Calling early on the day is appreciated.

**No-Show Policy:**
A "no-show" is someone who misses an appointment without calling 24 hours in advance to cancel. There will be a $20.00 charge to the patient if an appointment is missed. If a patient "no-shows" three times, they may be discharged from the office without notice.

Psychiatric Services FW PC is a treatment facility and not a forensic psychiatry office. We do not agree to participate in court proceedings. Diagnoses given are considered provisional and are based on patient history. Patients, their families and caregivers (including DFCS, group homeowners, state agency representatives) agree to compensate Psychiatric Services for any time spent on preparing subpoenas, court mandated appearances, depositions (over the phone or in person) or any other legal issues, at the rate of eight hundred and fifty dollars an hour ($850.00/hour).
I am the patient, or the legal representative and I have read and consent to this policy.

________________________________________
Name of Patient / Authorized Caregiver (If patient is under 18 years old)

________________________________________
Signature of Patient / Authorized Caregiver (If patient is under 18 years old)          Date

# Psychiatric Services FW PC

## Authorization for Disclosure of Health Information

| | |
|---|---|
| ______________________ Name of Patient | ______________________ Birth Date |
| ______________________ Street Address | ______________________ City, State, Zip Code |
| I hereby authorize | To disclose my protected health information as described below to: |

______________________
Name

______________________
Street Address

______________________
City, State, Zip Code

______________ Phone ______________ Fax

**Psychiatric Services FW PC**
**7806 West Jefferson Blvd, Suite C,**
**Fort Wayne, IN 46804**
**Tel: 260-203-4188**
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**Information to be released:**

- ☐ Medical History, Examination Report
- ☐ Treatment or Tests
- ☐ Sexually Transmitted Disease
- ☐ Developmental Disabilities
- ☐ Alcoholism
- ☐ Other (please specify): ______________________
- ☐ Surgical Reports
- ☐ X-ray Reports
- ☐ Laboratory Reports
- ☐ HIV Test Results
- ☐ Consultations
- ☐ Hospital records
- ☐ Allergy Records
- ☐ Mental Health
- ☐ Drug Abuse
- ☐ Prescriptions

A listing of the statutory exceptions to release of HIV test results without consent is available.
Purpose for need of Disclosure ____________ at request of the individual OR ______________________
I understand that the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my heath information might be re-disclosed without obtaining my authorization.

**I understand that I have the right to:**

➢Receive copy of this authorization.
➢Refuse to sign this authorization and that treatment, payment, enrollment in a health plan or eligibility for health care benefits may not be contingent on my signing this authorization.
➢Revoke this authorization, except to the extent that the person(s) and or organization(s) listed above have already made in reference to this authorization.
This authorization will remain in effect until the following date(s):______________________

______________________
Name of Patient / Authorized Caregiver (If patient is under 18 years old)

______________________
Signature of Patient / Authorized Caregiver (If patient is under 18 years old Date

# Controlled Medication Policy Consent

It is the policy of **Psychiatric Services FW, PC** to closely monitor the use of controlled medications prescribed to our patients. These medications include, but are not limited to, benzodiazepines, stimulants, sleep medication, pain medication and addiction medication. **These medications carry a risk of addiction, often used illegally and, if not managed appropriately, may cause serious injury and/or death**. **If I am prescribed Medication Assisted Treatment (for example Buprenorphine treatment) I agree to keep, and be on time to, all my scheduled appointments**. **I agree to conduct myself in a courteous manner in the doctor's office. I agree not to sell, share, or give any of my medication to another person.** I understand that such mishandling of my medication is a serious violation of this agreement and would result in my treatment being terminated without any recourse for appeal. I agree not to deal, steal, or conduct any illegal or disruptive activities in the doctor's office. I understand that if dealing or stealing or if any illegal or disruptive activities are observed or suspected by employees of the pharmacy where my medication is filled, that the behavior will be reported to my doctor's office and could result in my treatment being terminated without any recourse for appeal. **I agree that my medication/prescription can only be given to me at my regular office visits. A missed visit may result in my not being able to get my medication/ prescription until the next scheduled visit. I agree that the medication I receive is my responsibility and I agree to keep it in a safe, secure place. I agree that lost medication will not be replaced regardless of why it was lost. I agree not to obtain medications from any doctors, pharmacies, or other sources without telling my treating physician.** I understand that mixing this medicine with other medications, especially benzodiazepines (**for example, Valium, Klonopin, or Xanax**), can be dangerous. I also recognize that several deaths have occurred among persons mixing buprenorphine and benzodiazepines (**especially if taken outside the care of a physician, using routes of administration other than sublingual or in higher than recommended therapeutic doses**). I agree to read the Medication Guide and consult my doctor should I have any questions or experience any adverse events. **I agree to take my medication as my doctor has instructed and not to alter the way I take my medication without first consulting my doctor. I understand that medication alone is not sufficient treatment for my condition, and I agree to participate in counseling as discussed and agreed upon with my doctor and specified in my treatment plan. I agree to abstain from alcohol, opioids, marijuana, cocaine, and other addictive substances (except nicotine). I agree to provide random urine samples and have my provider test my blood alcohol level. I understand that any violations to the above may be grounds for immediate termination of treatment.**

1. **Patients need to complete a scheduled and/or random urine screen to monitor their compliance while on controlled medication.**
2. **If a patient has a positive urine drug screen for an illicit / recreational substance, we will taper off or immediately discontinue any controlled medications currently being prescribed.**
3. **If a patient has no evidence of the prescribed medication in the urine screen two consecutive times, we will taper off or immediately discontinue any controlled medications we are prescribing.**
4. **Additional prescriptions will not be given if the patient runs out of the controlled medication prescribed, i.e. uses the month prescription in less than 30 days.**
5. **If a patient's prescribed medications are stolen, they must present a police report to verify theft in order to receive a new prescription before it is due.**
6. **Patient is made aware that he/she can only receive controlled medication prescriptions from our office. If patient is obtaining similar medications from another medical office as well; no further prescriptions will be given from our office for these medications.**
7. **Abuse/diversion/medication seeking behaviors will result in termination of care and a referral to another psychiatry office. I am the patient, or the legal representative and I have read and consent to this policy.**

________________________________________________

Name of Patient / Authorized Caregiver (If patient is under 18 years old)

________________________________________________

Signature of Patient / Authorized Caregiver (If patient is under 18 years old) Date

**Psychiatric Services FW PC**

# Urine Test Authorization and Consent

I hereby authorize and give my full consent to allow **Psychiatric Services FW, PC** to collect and test a specimen of my urine or send out to a laboratory for screening, to detect the presence of illicit / recreational substances, alcohol, and / or prescription medication. This authorization and consent form has been explained to me in a language I understand. I have been told that if I have any questions about the urinalysis, I can ask such questions and they will be answered. I understand this is a legal and binding document. I also understand that the results of this test will be confidential.

1. I understand that Psychiatric Services will bill my insurance for a 12-panel cup test. However, certain insurances will only cover 1 panel. I understand if my insurance only covers 1 panel, then I will be required to pay for the other 11 panels at which Psychiatric Services will charge a flat rate of $20. This fee will cover the other 11 UDS panels.

2. I understand that if my insurance does not pay for the Urine Drug Screen (UDS), I will be required to pay $20 for the Instant Drug Test Cup (IDT-C).

3. I understand that I have other options available if a urinalysis is needed prior to my appointment. Other options available are LabCorp, hospitals, and my PCP. I understand I should be tested within 2 days of the appointment and the results must be faxed to our office within 1 day before the appointment if I decide not to be tested at Psychiatric Services, PC.

______________________________________________

Name of Patient / Authorized Caregiver (If patient is under 18 years old)

______________________________________________

Signature of Patient / Authorized Caregiver (If patient is under 18 years old ) Date

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