ARBOR PSYCHIATRIC AND WELLNESS CENTER

EXISTING PATIENT INFORMATION

First Name: _____ Last Name: _____ Middle Initial: ____

DOB: ____-_____-_____ Age: _____ SSN: _____-_____-_____ Marital Status: S M W D

Mailing Address: _____

City, State, Zip: _____

Home Phone: _____ Cell Phone: _____

E-mail: _____

I consent to receive communication using voicemails, text messages, and email (Initial) _____

Parent/Guardian Name:_____

SSN:_____-_____-_____ DOB: _____/_____/_____ Phone: _____

Email: _____

Emergency Contact

I consent for communication with my emergency contact in the event I cannot be reached for emergency safety concerns, appointments, billing, or other concerns related to managing my care.

Contact Name: _____ Relationship: _____

Phone: _____ Email (if applicable): _____

Responsible Party/Primary Insurance Information

Primary Insurance: _____Name of Subscriber: _____

Subscribers DOB: _____ ID #: _____ Group #: _____

Subscriber Address: _____

Subscriber Employer: _____

If applicable, Secondary Insurance: _____ ID #: _____

I authorize Arbor Wellness, LLC and appropriate independent contractors to release any information acquired in the course of examination and treatment to my insurance carrier. This authorization shall remain valid until my written notice is given revoking the authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance. This signature will also authorize consent to treatment for the above-named individual.

Signature of Patient/Parent/Guardian: _____ Date: _____

ARBOR PSYCHIATRIC AND WELLNESS CENTER

PLEASE REVIEW OFFICE POLICY HIGHLIGHTS

Arbor Psychiatric and Wellness Center staff want all patients to review important office policies. Please note, that some of these policies may have changed since you signed your original paperwork. Please contact the office with any questions or concerns.

EMERGENCY SERVICES. Arbor Psychiatric and Wellness Center is not an emergency clinic. After hours, holidays, and weekends, I am to contact 911 or go to the nearest emergency room in the event of a mental health crisis or emergency. My providers are accessible through a 24-hour answering service if there is an urgent need.

FINANCIAL POLICY. Acceptable methods of payment include cash, check, or credit card. A credit card authorization can be signed to keep card information on file to easily make payments outside of the office. All balances should be addressed within thirty days of receiving statement via payment or communication with staff regarding payment plan. Past due accounts and non-payment may result in medication delays. If your account becomes past due, we will take necessary steps to collect this debt. Referral to a collection agency may adversely impact your credit record. Accounts turned over to collection agencies may also result in you being dismissed for non-payment as a patient from our office.

MISSED APPOINTMENTS AND LATE CANCELLATIONS. Failure to keep your scheduled appointment will result in a fee of $50, unless you cancel at least twenty-four (24) hours prior to the appointment time. Showing up late (more than 10 minutes) for an appointment may result in immediate cancellation of that appointment and no show fee. Failure to show for your appointment two times may result in termination of services. *Frequent missed or canceled appointments will result in the denial of refill requests.*

MEDICATIONS. Attending appointments is required for medication refills. If you are prescribed a controlled substance, you will be asked to sign an agreement acknowledging your understanding of requirements to receive this medication. Events that may cause concern regarding the use of controlled substances may include but are not limited to early refill request, prescriptions being filled for same type of medication by multiple providers, appearance or concern of overuse of medications. Our providers reserve the right to terminate treatment with a controlled substance at any time.

MEDICATION REFILLS. *It is important to keep your scheduled appointment to ensure that you receive timely refills.* No shows or repeated cancellations will result in a denial of refills. If you are on a controlled substance, this includes some medications used in the treatment of ADHD, insomnia, and anxiety, our office policy is that you are required to be seen every 3 months for these refills. *Refills will not be given on these medications if you have not been seen within the past 90 days.* Please allow 24-48 hours for prescription refills. Please contact your pharmacy for refills unless otherwise directed.

By signing below, you certify that you have read and understand the terms stated in the above agreement. You indicate that you understand the above policies for emergency services, financial agreement, missed appointment and late cancellations, medication prescribing and medication refills.

Print Patient Name: _____ Date of Birth: _____

Signature of Patient/Guardian: _____ Date: _____

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