Dr. Iospa Psychiatry Consulting PC

PATIENT INFORMATION AND POLICIES.

LAST NAME: _____ FIRST NAME: _____ DATE OF BIRTH _____

ADDRESS: _____

CITY: _____STATE: _____ZIP: _____

HOME PHONE #: _____ MOBILE #: _____

WORK #: _____ EMAIL ADDRESS:_____

PATIENT EMPLOYED BY: _____ OCCUPATION: _____

SEX: **M** **F** AGE: _____ SS#: _____ TODAY'S DATE: _____

MARITAL STATUES (circle one) SINGLE/ MARRIED/ DIVORCED/ SEPERATED/ WIDOW.

REFFERRED BY: _____

EMERGENCY CONTACT INFORMATION

NAME OF FRIEND OR RELATIVE: _____

RELATIONSHIP TO PATIENT: _____

PHONE #: DAY TIME: _____ EVENING: _____

PRIMARY INSURANCE

MEDICARE UNITED HEALTHCARE (AARP) OXFORD OTHER: _____

PERSON RESPONSIBLE FOR ACCOUNT (LAST NAME): _____ (FIRSTNAME)_____

RELATIONSHIP TO PATIENT: SELF SPOUSE CHILD

DATE OF BIRTH: _____ SS#: _____

ADDRESS IF DIFFERENT FROM PATIENT _____

PERSON RESPONSIBLE EMPLOYED BY: _____ OCCUPATION: _____

INSURANCE COMPANY: _____ GROUP #: _____ ID#: _____

SECONDARY INSURANCE

IS PATIENT COVERED BY ADDITIONAL INSURANCE? YES NO

PERSON RESPONSIBLE FOR THE ACCOUNT (LAST)_____((FIRST)_____

ADDRESS (IF DIFFERENT FROM PATIENT)_____

PERSON RESPONSIBLE EMPLOYED BY_____ OCCUPATION _____

INSURANCE COMPANY _____ GROUP # _____ ID # _____

PHARMACY INFORMATION

NAME OF THE PHARMACY _____ PHONE # _____

ADDRESSS _____

CANCELLATION/ MISSED APPOINTMENT POLICY

Our goal is to provide quality medical care in a timely manner. In order to do so, we have had to implement an appointment/ cancelation policy. This policy enables us to better utilize available appointments for our patients in need of medical care.

If you are unable to keep an appointment, please call the office at least 24 hours in advanced to avoid the cancellation fee of $150. _____Initials here

PLEASE READ THE FOLLOWING AND SIGN BELOW

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I hereby authorize my insurance benefits to be paid directly to the Physician. I understand that I am financially responsible for non-covered services. I authorize the release of any medical or other information necessary to process insurance claims on my behalf. _____Initials here

MEDICARE PATIENTS

I authorize any holder of medical or other information needed to determine benefits for this or a related Medicare benefits be made either to me or to the party who accepts assignment._____Initials here

NOTICE OF PRACTICES ACKWLEDGMENT

By signing below, I acknowledge that I have been provided a copy of Notice of Privacy Practice

_____ _____ _____

Responsible party signature Relationship Date