PREMIER PSYCHIATRY
PSYCHIATRIC AND BEHAVIORAL HEALTH SERVICES

10745 165th Street
Orland Park, IL 60467

9830 S Ridgeland Ave, Suite 6
Chicago Ridge, IL 60415

P: 708-799-8384
F: 708-799-1305

PATIENT ACCT #:_____ PATIENT REGISTRATION FORM DATE: _____

PATIENT INFORMATION (Please write information about the patient here.)

Patient Name: Last	**First MI**	**Sex**	**Birthdate**
Address	**City**	**Zip**	**Phone**
Email	**Marital Status**	**SS#**	**Referring Doctor**
Patient's Employer	**Occupation**	**Employment Status**	**Work Phone**

INSURANCE INFORMATION (Please write information about the patient's insurance here.)

Primary Insurance Company Name	**Secondary Insurance Company Name** (if applicable)
Insurance Company's Address	**Insurance Company's Address**
City State Zip	**City State Zip**
Insured's ID Number Group Plan Number	**Insured's ID Number Group Plan Number**

POLICY HOLDER INFORMATION (Complete the information below if the patient is NOT the POLICYHOLDER)

Primary Policyholder's Name DOB	**Secondary Policyholder's Name DOB**
Primary Policyholder's Address	**Secondary Policyholder's Address**
City State Zip Telephone	**City State Zip Telephone**
Employer's Name Telephone	**Employer's Name Telephone**
SS # Relation to patient Spouse Parent Other	**SS # Relation to patient Spouse Parent Other**
Employer Plan Coverage If CHAMPUS: Active Retired Deceased Yes No Branch of Service:	**Employer Plan Coverage If CHAMPUS: Active Retired Deceased Yes No Branch of Service:**

RESPONSIBLE PARTY INFORMATION Responsible party is: Patient Primary Policyholder Secondary Policyholder (Please complete the information below if the person responsible for paying the bill is not the PATIENT or the POLICYHOLDER.)

Responsible Party's Name Sex	**DOB SS #**
Address	**City State Zip**
Telephone	**Relation to Patient**

INSURANCE CLAIMS PAYMENT

I authorize the release of medical information or excerpts thereof, to any insurance company or third party payor for utilization management, audit purposes and/or the purpose of verifying the services rendered and obtaining payment of the account. I understand that execution if this authorization waives my right of confidentiality as to the material pursuant to this authorization.

Emergency Contact:_____ Relation:_____ Phone: _____

Refuse to Release Emergency Contact: Signature:_____ Date: _____

X_____ Date: _____

SIGNED (Patient, or parent if under 18 years of age)

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Our Office Policies

We thank you for choosing **Premier Psychiatry** and look forward to working with you! We strive to provide the very best care and to do so, we would like to take this opportunity to acquaint you with our office policies.

Authorization for Treatment

I authorize the psychiatric providers, therapists, and/or designees in charge of my medical care to administer any treatment as may be necessary or advisablein my diagnosis and treatment at Premier Psychiatry ("Facility"). This authorization includes, but is not limited to, routine diagnostic procedures, psychotherapy, laboratory tests, and the use of prescription medication. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to results of examination and treatment received at this Facility. I acknowledge that my care is under the direction of my treating physician(s) and the Facility will follow the instructions of my physician(s) in the provision on said care.

Appointments

If you have a preferred time slot, we recommend that you schedule your appointment several weeks in advance.

A scheduled appointment means that time has been reserved for you. Missing your appointments represents a lost opportunity for other patients who could have been seen in the time set aside for you. Arriving late may make it impossible for the doctor to have enough time to conduct a full appointment, and you may be asked to reschedule. The following fees are not reimbursable by your insurance company and will be your responsibility to pay before your next appointment:

$45 for Psychiatric Providers when canceling less than 48 hours prior to appointment
$125 for Psychotherapist for missing or canceling less than 48 hours prior to appointment

Multiple missed appointments or late cancellations make it difficult to provide adequate care to our patients and may lead to termination from the practice.

Appointment Reminders

As a courtesy, our office will attempt to remind you of your upcoming appointment approximately two business days before your visit. We cannot guarantee this service due to occasional staff shortages or incorrect contact information.

Even if you do not receive a reminder, you are still responsible for coming to your appointment.

Telephone Calls

In the event of a life-threatening emergency, immediately call 911 or go to the nearest emergency room. Phone calls during clinic hours cannot always be returned immediately, but are typically returned within 24-48 hours.

Physician Completed Forms & Letters

It is not uncommon for patients to request the completion of disability forms, personalized letters, etc. **Patients that request leave from work and require FMLA or disability paperwork need to have been seen a minimum of 3 visits prior to any paperwork being filled out.** There will be a charge to perform these non-routine requests, since they require additional time and resources to complete. We regret having to charge for these services and thank you in advance for understanding.

$15 Letters
$45 Forms/Paperwork

Financial Responsibility

If you will not be using insurance, we require payment in full at the time of service. If you will be using insurance, co-pays are due at the time of service. We can bill your insurance company on your behalf after your present proof of insurance coverage. Because each insurance plan is different, please familiarize yourself with the rules of your own, to ensure the plan's rules are met. Should your insurance company default on their agreement to pay, you are responsible for any remaining balance.

For your convenience, we accept cash, check and credit cards, and can maintain a credit card number on file for balance due. If a check is returned, there will be a $35 service charge.

We request that you notify our office of any changes in the following information: name, address, phone number, insurance, or marital status.

We are unable to accept Public Aid or Worker's Compensation cases.

Collecting Account Balances

If you are having financial difficulties, we are willing to discuss your various payment options. Unless you inform us about a problem with payment, past due accounts of 90 days may be turned over to collection. The patient or guarantor will be responsible for all reasonable costs of collection.

Prescriptions

In general, you will be provided a prescription with enough refills to last until your next expected appointment. Abruptly stopping your medication can cause unpleasant or potentially dangerous withdrawal symptoms and should be avoided. If you do require a refill between appointments, **please call our office during regular business hours, 2 or 3 days before you run out**.

Prescriptions are not refilled when our office is closed.

Failure to come to follow-up appointments as directed by the doctor may result in your doctor's inability to refill your prescription. This policy exists to ensure your own health and safety, as well as to comply with State and Federal laws regarding the issuance of prescription medications.

Notice of Privacy Practices

I have been given the opportunity to review the Facility's Notice of Privacy Practices for Protected Health Information. I understand that the facility has the right to change the Notice of Privacy Practices at any time, and that I may obtain a current copy at the Facility's office during normal business hours.

Patient's Rights and Responsibilities

I have been given the opportunity to review the Facility's Patient's Rights and Responsibilities. I understand that the Facility has the right to change the Patient's Rights and Responsibilities at any time, and that I may obtain a current copy at the Facility's office during normal business hours.

Discharge From

You have control over your care and have the right to terminate your care with us at any time. We reserve the right to discharge any patient from this practice at any time for failure to comply with office policies or treatment recommendations.

Coordination of Care

Do you want Coordination of Care between PCP, other health care provider and Release of Information to a Parent/Family Member?____Yes ____No
If yes, please Complete the following: Premier Psychiatry is Authorized to release Protected Health Information related to the Evaluation and Treatment of:

Patient's Name:_____

Date of Birth:_____

PCP Name/Phone:_____

Parent/Family/ Friend:_____

Address:_____

Phone _____ _____

Acknowledgement

I acknowledge that I have received and understand the office and financial policies of Premier Psychiatry (Pradeep Thapar, MD SC). By choosing to proceed I am also agreeing to abide by these policies.

Signature_____Date

If signing as a personal representative of the patient, describe the relationship and the source of authority to sign this form.

Relationship to Patient_____Print Name

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CONSENT TO TREATMENT WITH PSYCHOTROPIC MEDICATION

1. My doctor has explained to me that I have a mental/emotional disorder for which he is recommending psychotropic medication treatment. In the doctor's opinion, no other treatment, by itself, would currently be as effective in helping my condition.

2. I understand that the doctor is prescribing the smallest amount of medicine which, in his or her opinion, will be of help to me at this time.

3. I have been informed and given written information concerning any precautions I should take regarding activities and diet while on this medication.

4. I have been informed concerning possible side effects from taking these medications.

5. If this prescription is for major tranquilizers or neuroleptics, this medication can, in some persons, result in physical disorder of abnormal movements of the tongue, face, and extremities called Tardive Dyskinesia. I understand that this disorder may be permanent. I have been informed that my doctor and nurse will watch for any sign of this disorder.

6. I have had all questions concerning my mental/emotional disorder, and the psychotropic medications recommended for me, answered to my satisfaction at this time. I know that I can speak with my doctor or nurse concerning any other questions which I may have concerning these in the future.

7. I agree to:

A. Take the medication prescribed for me in the manner recommended by my doctor. B. Follow the doctor's recommendation for any laboratory test which may be needed because of taking this medication.

C. Report any possible side effects, or unexpected reactions, as soon as possible, to my doctor, nurse, client services manager or other staff.

D. Tell my doctor, nurse, client services manager, if, at any time I want to stop taking these medications, and the reason for my choice.

X_____ _____ / _____ / _____

Signature of Patient, Parent, Guardian, or Authorized Representative — Today's Date

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CONSENT TO THERAPY TREATMENT

By signing this form, you are consenting to become a patient for therapy by a Licensed Clinical Social Worker in the state of Illinois. All LCSW providers are licensed in the state of Illinois and also hold malpractice insurance. Here at Premier Psychiatry we have multiple therapeutic approaches that we will tailor to each individual, based on our initial evaluation of the patient.

Client's Rights

1. The client may ask questions on what to expect during the therapy sessions including therapeutic techniques and length of sessions provided.
2. The client is expected to productively participate in the therapy sessions.The therapist has the right to discharge the client from the course of therapy if the sessions are unproductive, non therapeutic or if client displays harmful or inappropriate behavior towards therapist or other staff at Premier Psychiatry.
3. The client may not contact the therapist outside of the Premier Psychiatry office including personal email, personal phone, social media or any other lines of communication outside of this office. If this occurs the therapist has the right to terminate treatment.
4. If the client has an emergency after hours and cannot speak with a therapist or other provider they are directed to go to the nearest emergency room for evaluation.
5. According to HIPPA laws the client has the right to review his or her medical records from Premier Psychiatry. Within limits provided for by law, all records and information acquired by the therapist shall be kept strictly confidential in accordance with HIPPA regulations and the NASW Code of Ethics.
6. Information will not be shared or revealed to any person, agency, or organization without the prior written consent of the client; through a signed release of information form. If the client wishes for the therapist to communicate with outside contacts such as DCFS caseworker, court appointed staff, or school staff the appropriate release of information must be on file.
7. Therapist will not complete any FMLA paperwork, emotional support animal paperwork, court documents, school forms etc on the first session. The Client must have an established relationship with a therapist and have been seen multiple times to determine if this is appropriate. The client must also pay a $35 charge for any paperwork completed.
8. If the therapist is subpoenaed for any court case on behalf of a client it will be the client's responsibility to pay additional fees for the therapist’s time for attending any court ordered appointments etc.
9. If the therapist feels that the client is a harm to themselves or others the provider has an obligation to notify the proper authorities including calling an ambulance for immediate treatment or the police department.
10. Therapist is also bound by law to notify DCFS in any case where the therapist feels there is child abuse.
11. The client is expected to schedule appointments on a regular basis and do their best to keep such appointments. Clients will be charged a $125 No Show fee if they do not keep their appointment. Clients must cancel at least 48 hours prior to appointment to avoid a No Show fee.

Client Signature: _____ Date: _____

Clients Printed Name: _____