JEANNE SERAFIN, MD
ADULT PSYCHIATRY

PATIENT INFORMATION

Patient Name:_____
Last First Middle Initial

Prior Name _____ Race: _____

Social Security Number: _____-_____-_____ Date of Birth:_____

Sex: _____ Marital Status:_____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Cell/Other: _____

Email: _____

INSURANCE INFORMATION

Name of Primary Insurance:_____ ID Number:_____

Subscriber Name:_____ Sub. DOB:_____

Sub. Social Security Number:_____ Relation to patient_____

Group Number:_____ Employer/ Group Name_____

EMERGENCY CONTACT INFORMATION

Person to notify/Next of kin: _____
Last First MI

Mailing Address: _____

City:_____ State:_____ Zip:_____

Telephone number:_____

JEANNE SERAFIN, MD
ADULT PSYCHIATRY

PROTECTED HEALTH INFORMATION

I,_____, give Jeanne Serafin, MD permission to make and disclose the following with the person listed below.

_____ Scheduling/ Cancelling Appointments

_____ Medication Questions (only in session)

_____ Speak with the provider regarding the patient (only in session)

Name;_____

Phone:_____

Relation to client:_____

CURRENT MEDICATION AND ALLERGIES

What medications are you taking for medical conditions?

_____

_____

Have you or are you currently taking psychiatric medications? Please list name and dose.

_____

_____

(use back of sheet if necessary)

Please list any allergies to medications:

_____

JEANNE SERAFIN, MD
ADULT PSYCHIATRY

CURRENT CONCERNS - Please circle all that apply:

Anxiety/Worry/Nervousness

Sadness/Depression

Anger/Temper

Irritability

Difficulty Sleeping

Change in appetite/weight

Loss of pleasure in activities

Concentration difficulties

Memory lapses

Low motivation

Alcohol or substance use

Impulsivity

Nightmares

Binge eating

Med. side effects

Thoughts of harming yourself

Thoughts of harming others

Low self-esteem

Paranoia/Suspiciousness

Hearing voices/noises

Seeing visions

Panic attacks

Racing thoughts

Recurring , unwanted thoughts

Mood swings

Loneliness

Risk-taking behaviors

Flashbacks

Restrictive eating

Other:_____

JEANNE SERAFIN, MD
ADULT PSYCHIATRY

Patient name:_____ DOB:_____

SUMMARY OF PATIENT FINANCIAL RESPONSIBILITY

I appreciate the confidence you have shown in choosing me to provide your mental health care. The service you have selected implies a financial responsibility on your part. This obligates you to ensure that fees are paid in full. If you are using insurance I will verify your insurance and bill your carrier on your behalf. You are ultimately responsible for the payment of your bill. You give me permission to bill your insurance.

If you are using insurance you are responsible for any payment of deductions, co-payments and co-insurance as determined by your insurance carrier. Payment is expected at the time of service. You are responsible for any amounts not covered by your insurance or if you are a full fee client. If the insurance carrier denies your claim you are responsible for the payment in full. (see fee schedule).

I have read the above policy regarding my financial responsibility to Jeanne Serafin, MD for providing services to me or the above named patient.

Patient Signature:_____ Date:_____

Guarantor Signature:_____ Date:_____
(if guarantor is not the patient)

CO-PAY POLICY// FULL FEE POLICY

Co-payments are expected at the time of visit.

Full fee clients are expected to pay the fee at the time of visit.

Patient/Guarantor Signature:_____

Date:_____

CANCELLATION / NO SHOW POLICY

48 hour notice is required if you are to miss an appointment. If the notice is less than

48 hours you will be billed for the full fee for the visit, not the insurance amount or copayment. This fee will be waived in the face of an emergency.

Patient/Guarantor:_____
Date:_____

JEANNE SERAFIN, MD
ADULT PSYCHIATRY

OFFICE POLICIES

I appreciate the ability to provide care for you. These policies help to ensure the treatment will go smoothly. Please note:

At each visit you must bring your *most current insurance card*, if using your insurance, photo id and method of payment. Cash, check and VENMO is accepted for payment. A receipt will be given.

Cancellation/No show: Please notify the office 48 hours in advance of a missed appointment. Failure to do that will result in the full fee being billed for the visit, not insurance fee or copayment. This fee cannot be paid by a flex spending card or HSA card. This fee is cancelled in the face of an emergency.

Prescription Refills: Clients are given adequate refills at each visit. it is expected that you will get your prescription in person during the session. If you run out before your next session there will be a $25.00 fee to phone into the pharmacy. Please allow 72 hours for refills to be called in. Controlled substances will only be refilled during a scheduled session.

I am not able to authorize medication changes by email or by phone.

Confidentiality: Your treatment and medical records are confidential and **will not** be released without your written permission. The only exception to this is the case where patient/provider or others are in imminent danger. There is a fee for release of medical records.

Documents/Letters/Forms: Please allow 10 days for any documentation requested. The fee for the paperwork will be prorated on the hourly service fee.

Please sign this form indicating that you have understood all policies stated. Don't hesitate to ask any questions about office policies and payment.

Patient/Guardian Signature:_____

Date:_____