Alpha Psychiatric Associates, North Carolina
New Patient Registration Form

PATIENT DEMOGRAPHY

Patient's Name (First/Middle/Last) Date of Birth SSN

Mailing address Street City State Zip

Phone: Home Mobile Work E-mail

Preferred contact: Call Home Call Mobile
Text (Mobile) E-mail
OK to leave Voice Mail

Marital Status Sex Male Female

Employer Name Employment Status

Parent/legal guardian name Relationship to patient Primary contact Info.

Address: Street city State zip

Emergency Contact Name: Relationship to Patient Contact Number

Referral Name: Practice Name Office

Which category best describes your race? Please Specify your ethnicity

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Pharmacy for Prescription Medication

Local Pharmacy name Location Mail order pharmacy name

PRIMARY INSURANCE INFORMATION

Name of the primary insurance

Subscriber ID

Effective Date

If the patient is NOT the primary subscriber, please fill the following:

Subscriber's Name (First/Middle/Last)

Date of Birth

Sex Male Female

Relationship to Patient

SECONDARY INSURANCE INFORMATION

Name of the insurance

Subscriber ID

Effective Date

If the patient is NOT the primary subscriber, please fill the following:

Subscriber's Name (First/Middle/Last)

Date of Birth

Sex Male

Female

Relationship to patient

Financial Assignment and Patient Responsibility Information

I authorize release of any information acquired in the course of treatment necessary to complete and file medical claims to my insurance company or Medicare on my behalf. I hereby acknowledge financial responsibility for costs of services rendered for me or for the person whose account for which I am acting as guarantor. I authorize (assign) any insurance or Medicare benefits to be paid directly to Alpha Psychiatric Associates, PLLC or its assignees. I am responsible for any non-covered services, supplies, co-payments or deductible. This acceptance and assignment will be in force for all future services by all practitioners from this office.

I have reviewed the Privacy Policy and Policies and Procedures of Alpha Psychiatric Associates. I understand that I can refer to these online by visiting www.alphapsychiatry.com or by requesting a paper copy for reference.

Signature of Patient

Signature of Guarantor (if not patient)

Printed Name of Patient

Printed Name of Guarantor

Date

Date

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Fax: 919-246-4420
www.alphapsychiatry.com

Treatment Agreement

Thank you for choosing Alpha Psychiatric Associates for your psychiatric care. We are committed to providing the highest quality of treatment. The following is a statement of our Financial Policy. Please read and sign prior to your first appointment.

1. Payment is due at the time of service.
2. Our providers are credentialed with several insurance providers. If we are not contracted with your insurance carrier, you are responsible for full payment at the time of service. If you have a deductible, you are responsible for paying each visit in full at the contracted rate for your insurance carrier until you have met your deductible obligation with the carrier. If your insurance carrier requires a co-payment, this is to be paid at each visit. Please notify the office if you have a change in insurance coverage. Authorizations for your first visit are your responsibility. You are responsible for payment for services rendered regardless of any determination made by an insurance company.
3. Insurance will not pay for missed appointments. Unless cancelled at least 24 hours (business day) in advance, it is our policy to charge the office rate for the missed appointment. Reminder texts and/or emails are considered only a courtesy. You are ultimately responsible for keeping a record of the day and time of your appointment.
4. ***Please note that we are unable to accept text messages to cancel an appointment. Please call or email. During inclement weather, please check if our office is open, we expect you to call to notify us if you can't drive.***

I, ____ (patient name), have reviewed the Policies and Procedures of Alpha Psychiatric Associates PLLC and understand and agree to these policies. I understand that payment for all professional services rendered is the responsibility of the patient or the guarantor.

I also have reviewed the Notice of Privacy Practices for Alpha Psychiatric Associates. I understand that as part of my health care, Alpha Psychiatric Associates maintains paper and/or electronic records that contain Protected Health Information I understand that Alpha Psychiatric Associates maintains a Notice of Privacy Practices that provides a complete description of Protected Health Information uses and disclosures. The most recent version of this Notice is displayed in the waiting room area and is available on the practice's website.

I understand that after treatment begins, I have the right to withdraw my consent to treatment at any time and for any reason. However, I will make every effort to discuss my concerns about my progress with my provider before ending treatment with them.

I understand that no specific promises have been made to me by my provider or anyone at Alpha Psychiatric Associates about the results of treatment, the effectiveness of the procedures, medications that will be prescribed, or the number of sessions necessary for treatment to be effective.

Providers may terminate their care agreement for non-complinace by patient such as not keeping up with follow-up appointments, not taking medications and defaulting on payment obligations.

________________________________	________________________________
Signature of Patient (or Guardian)	Printed name of Representative (if not patient)
Date Signed	Relationship of Representative to Patient

Alpha Psychiatric Associates
401 Keisler Dr. Cary NC 27518
6224 Fayetteville Rd Ste 105 Durham NC 27713
www.alphapsychiatry.com

New Patient Information

Name: Date of Birth

Address: City State Zip

Referred by:

Reason for appointment

Med. Provider Phone:

Primary Care Phone:

Have you had any of the following medical conditions?

Seizures, epilepsy	Heart Disease/Heart Attack
Head Trauma, loss of consciousness	High Cholesterol
Acid Reflux	Diabetes, Pre-diabetes
Irritable Bowel Syndrome	High Blood Pressure
Migraine Headaches	Low Thyroid, High Thyroid
Chronic Sinusitis	Stroke or TIA (Mini Stroke)
HIV	Chronic Pain
Hepatitis B or Hepatitis C	Cancer
Vitamin D Deficiency	Kidney Disease
Vitamin B12 Deficiency	Pituitary Tumor
Other	

Current Medications - Please include over the counter, vitamins, supplements

Medication Name	Pill Strength	Frequency	Reason

Medication you are allergic to	Reaction

Surgical History

Surgery	Date	Reason

Past Psychiatric Treatment

Hospitalizations

Suicide Attempts

Self Harm

Other Info

Substance Use History

Alcohol How much?

Are you or your family concerned about your drinking?

Yes No

Caffeine How much/Day

Nicotine How much/Day

Street Drugs How much

Others How much

Developmental History (problems, complications, delays in development from pre-birth through early childhood.)

Education History (Please list any problems you had in school and your highest level of education.)

Work History (Any employment problems that may be related to mental health concerns.)

Psychosocial History (Any interpersonal problems, marriage history, verbal, physical or emotional abuse.)

Legal History: None / DUI /Arrest / Jail or Prison time

Family History (Please list first names, ages and medical or mental health history of family members.
Please indicate if there is any adoption history including your own.)

Spouse

Children

Siblings

Parents

Other (if relevant)

Life Style

Hobbies

Exercise

Pets?

Living with
family, friends?

Other important
social aspects