

CEDAR CENTRE PSYCHIATRIC GROUP L.L.P.

PLEASE PRINT LEGIBLY!! PLEASE FILL OUT, SIGN AND DATE BOTH SIDES OF THE FORM!

Patient's Full Name _____

Address _____

City, State & Zip _____

Home Phone _____ Social Security # _____

Date of Birth _____ Male Female Student full time part time

Guarantor's Full Name _____

Address _____

City, State & Zip _____

Home Phone _____ Social Security # _____

Date of Birth _____ Male Female Work Phone _____

Employer _____ Marital Status _____

Emergency Contact:

Name _____ Phone _____ Relationship _____

INSURANCE INFORMATION

Insurance Company Name _____

Claims Address _____

City, State & Zip _____

Insurance Phone # _____ Precertification Required? Yes No

Name of Subscriber on Card _____

Date of Birth _____ Employer _____

Policy # _____ Group # _____

Secondary Insurance Company Name _____

Claims Address _____

City, State & Zip _____

Insurance Phone # _____ Precertification Required? Yes No

Name of Subscriber on Card _____

Date of Birth _____ Employer _____

Policy # _____ Group # _____

I authorize payment of medical benefits to Cedar Centre Psychiatric Group. I understand Cedar Centre will file my insurance as a courtesy to me, but I am financially responsible and agree to pay Cedar Centre within 60 days, even if my insurance has not yet paid.

Name _____ **Date** _____

NOTICE TO ENROLLEES OF ANY HMO PLAN:

If your benefit plan requires you to contact your Mental Health Plan, prior to receiving services at our office and you have not done so, you will be responsible for payment in full of services received.

Please initial here: _____

CONSENT TO RELEASE MENTAL HEALTH INFORMATION

I, the undersigned, hereby authorize Cedar Centre Psychiatric Group to disclose to:

Name of Insurance Company

Address

The following information:

- A) Administrative Data (i.e., name, address, age)
- B) Diagnosis
- C) Voluntary or involuntary treatment status
- D) Estimated time during which treatment might continue
- E) Treatment information including prescriptions & current status

I understand that the information is to be used for billing purposes; I further understand that this will be a lifetime agreement, which I may revoke at any time by sending written notice to Cedar Centre Psychiatric Group.

I understand that any release, which has been made prior to my revocation and which was made in reliance upon this authorization, shall not constitute a breach of my rights to confidentiality. I understand that I may request to review the disclosed information by contacting Cedar Centre Psychiatric Group.

A photocopy of this consent shall be deemed the same as the original.

Name

Date



CEDAR CENTRE

PSYCHIATRIC GROUP, L.L.P.
P.O. Box 1408
Cedar Rapids, IA 52406-1408 (319)-365-3993

Patient Name _____

Account # _____

1) ---AUTHORIZATION FOR TREATMENT

I have chosen to receive treatment through Cedar Centre Psychiatric Group for myself or my minor child. I understand I may terminate at any time. I understand that treatment is a cooperative effort between myself and my doctor and/or counselor. I understand that I have a right to be fully informed regarding the benefits or potential problems associated with any treatment I may receive. I understand that information collected about me shall be confidential unless a Release of Information is given. Any Release of Information is valid only for the time period indicated and may be rescinded at any time. Exceptions will apply only in circumstances that legally require sharing information.

2) ---AUTHORIZATION FOR REMINDER CALLS

I authorize my health care provider to use an automated telephone system. The name of my scheduled treating provider; and the time and place of my scheduled appointment will be disclosed for the limited purpose of contacting me to notify me of a pending appointment. I also authorize my healthcare provider to disclose limited protected health information regarding pending appointments to third parties that may answer my telephone, and leave a reminder message on my voice mail system or answering machine.

3) ---ACKNOWLEDGMENT OF OFFICE POLICY

I hereby acknowledge that I was given the opportunity to receive and read a copy of the Cedar Centre Psychiatric Group's Office Policy.

4) ---ACKNOWLEDGMENT OF PRIVACY POLICY

I hereby acknowledge that I was advised a copy of the Cedar Centre Psychiatric Group's Notice of Privacy Practices is posted on their website. I also understand I can request a paper copy at any time.

Acknowledgment and agreement of above numbers #1, #2, #3 & #4

Signature

Date

Relationship

Witness

Cedar Centre Psychiatric Group – Please provide medical information as best you can

Name: _____ DOB: _____ Date: _____

Allergies: _____

Medications (include herbs, supplements, vitamins, over the counter, eye drops, ALL medications please): _____

Past psychiatric medications: _____

Hospitalizations/Surgeries (include all medical/psychiatric, year and reason): _____

Have you ever had the following:

Birth Injury(Blue baby): NO YES(explain): _____

Head injuries: NO YES(explain): _____

Loss of consciousness or concussions? NO YES(explain): _____

Seizures: NO YES(explain): _____

Meningitis or Encephalitis: NO YES(explain): _____

ECT(shock treatments): NO YES(explain): _____

Serious Accidents: NO YES(explain): _____

Do you smoke: NO YES

Do you drink alcohol: NO YES

Do you have any problems with the following (if you do, please circle and describe below):

Constitution: Fever, Chills, Sleep problems, Appetite or weight changes

HEENT: Vision, glaucoma, hearing problems, smelling problems, taste or swallowing problems

Blood and Immune: weak immune system, allergies, HIV/Aids, bleeding disorder, lymph disorder, cancer

Neurologic: Headache, Tremor, Dizzy, Numbness, Multiple Sclerosis, Parkinson's, Dementia, Memory problems, Restless legs, Seizures, Stroke, Brain or spinal injury or infection, Pinched nerves

Hormones: Fatigue, Tired, Excessive sweating, Hot flashes, Libido changes, Thyroid, Diabetes, Menopause

Gastrointestinal: Abdominal pain, Nausea, Vomiting, Diarrhea, Constipation, Blood in stools, Hepatitis

Cardiovascular: Chest pain, Palpitations, Heart attacks, Heart murmurs, Heart failure, fatigue with activity

Pulmonary: Asthma, COPD, Emphysema, Chronic cough, Wheezing, Coughing up blood

Rheumatology: Fibromyalgia, Chronic Fatigue, Arthritis, Lupus

Skin: Rashes, Easy bruising, Eczema, Psoriasis, Acne, breast problems

Musculoskeletal: Joint problems, Stiffness, Osteoporosis, Muscle or bone diseases, sciatica

Genitourinary: Kidney problems, Urine problems, blood in urine, prostate problems, genital infection

Other details or problems: _____

Are you pregnant? NO YES Are you intending to become pregnant while in treatment? NO YES

Patient (or Guardian) Signature

Provider Signature