

Mineral Area Psychiatric Services LLC

555 West Pine Street Farmington, MO 63640

Phone (573) 330-0732 Fax (573) 218-0716

mineralareapsychiatricervices@outlook.com

Name: _____ Date of birth: ____/____/____

Address: _____ SSN: ____-____-____

Phone Number: (____) _____ Email Address: _____

Pharmacy: _____ Primary Physician: _____

Chief Complaint/ Reason for being seen today: _____

SOCIAL HISTORY:

Where were you born? _____ Education: _____ Military: _____

Race: _____ Religious accommodations: _____ Occupation if applicable: _____

Marital Status: Single Married Divorced Widowed Number of Children: (boys/girls) _____

Tobacco use: _____ Alcohol use: _____

Drug Use: _____ Current or past legal issues: _____

Sleep (describe): _____ Weight changes: _____

Family History of medical or psychiatric illnesses: _____

Current Medical Conditions: _____

Medication Allergies: _____

Current Medications (please list all): _____

History of Abuse: _____

Patient Signature: _____ Date/Time: _____



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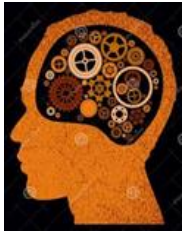
Information Sheet

- We are unable to see children. All patients will be 18 years of age and older
- Benzodiazepines will be minimally prescribed and any new prescriptions will have a discontinuation plan prior to initiation.
- Anyone prescribed a benzodiazepine will be subjected to Urine Drug Testing, prior to filling of prescription.
- No stimulants will be used at this practice.
- Please notify the provider if you are seeking disability. All patients must have been seen for 6-12 months, consecutively, before any documentation can be completed.
- All cancellation must be made 24 hours prior to appointment. Any cancelations without notice or no shows will be charged a \$30.00 dollar fee.
- 2 or more cancelations, within a 6 month period, may result in you being discharged from services through Mineral Area Psychiatric Services.
- You are responsible for any Co-pays, Co-Insurance, deductibles, and outstanding balances, at the time of your appointment.
- Any rejection or remaining balance, by your insurance company, must be paid prior to the next appointment.
- A service fee of \$30.00 will be charged on all returned checks. Balance must be paid before scheduling follow up appointment.
- There are associated fees with completion of requested forms. These fees will be determined by complexity and time associated with the form. Cost will be discussed at appointment.

By signing this document you are acknowledging and accepting on information provided.

Signature: _____

Date: _____



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HIPAA AUTHORIZATION FORM

Patient Name: _____ Date: _____

I give my permission for Mineral Area Psychiatric Services LLC to release ANY information about my mental health condition, prescriptions, and financial account to:

Name: _____

Name: _____

Name: _____

Below, I give my permission for Mineral Area Psychiatric Services LLC to release prescriptions, samples, forms and medical records to:

Name: _____

Name: _____

Name: _____

The above mentioned person(s) **will be required to provide photo ID** when picking up requested items.

Patient name: _____ Date of birth: _____

Patient signature: _____

By signing on the line below, I acknowledge that I was provided access to the Notice of Privacy Practices of Mineral Area Psychiatric Services LLC.

Print Name: _____ Date of birth: _____

Patient Signature: _____

For Personal Representation of the Patient (if applicable)

Print Name of Personal Representative: _____

Representative's Relationship (i.e. parent/guardian/other, etc.): _____

Signature of Personal Representative: _____

_____ I refuse to acknowledge I was provided access to the Notice of Privacy Practices of Mineral Area Psychiatric Services LLC.

Signature of Practice Employee

Date



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PATIENT REGISTRATION (please print)

1. Patient's Full Name _____
Last First Middle Name Preferred
2. Sex: M F
3. Race: (Please Circle) American Indian, Asian, African American, Native Hawaiian or Pacific Islander, Caucasian, Other, Patient Declined
 Ethnicity: (Please Circle) Non-Hispanic, Hispanic, Patient Declined
4. Patient's Social Security # _____ 5. Date of Birth: _____ Age: _____
6. Patient's Home Address _____
Street or Route City State Zip
 Patient's Email Address _____
7. Primary Care Doctor _____ 8. Financial Responsibility: __ Patient __ Other
9. Patient's Home Phone (____) _____ Patient's Work Phone (____) _____ Patient's Cell Phone (____) _____
10. Is the Patient Currently Employed? Yes No
 Patient's Employer _____
 Employer's Address _____
Street or Route City
11. Patient's Marital Status S M D W Sep.
12. Person we may contact in case of an emergency: Relationship _____
 Name _____ Phone # _____
 Address _____
Street or Route City State Zip

INSURANCE INFORMATION – We cannot file your insurance without complete information and a copy of your insurance cards. Please bring your insurance card with you to the front desk when you have completed this form.

PRIMARY INSURANCE COVERAGE

13. Insurance Company _____ Address _____
14. Subscriber's Name _____ 15. Subscriber's Sex: M F
16. Subscriber's Date of Birth _____ 17. Subscriber's Social Security # _____
18. Patient's Relationship to Subscriber Self Spouse Child Other
19. Subscriber's Employer _____
20. Subscriber's ID # _____ 21. Group # _____

SECONDARY INSURANCE COVERAGE

22. Insurance Company _____ 23. Address _____
24. Subscriber's Name _____ 25. Subscriber's Sex: M F
26. Subscriber's Date of Birth _____ 27. Subscriber's Social Security # _____
28. Patient's Relationship to Subscriber Self Spouse Child Other
29. Subscriber's Employer _____
30. Subscriber's ID # _____ Group # _____

FINANCIAL AGREEMENTS AND AUTHORIZATION FOR TREATMENT: I hereby authorize I understand that, to the extent permitted by applicable law, I am and I agree hereby to be, financially responsible to Mineral Area Psychiatric Services LLC for charges not covered by this agreement, and I hereby guarantee payment to Mineral Area Psychiatric Services LLC on demand for all such charges.

Signature: _____ Date _____

Please check one: __ Patient __ Auth. Rep