# Mineral Area Psychiatric Services LLC

**555 West Pine Street Farmington, MO 63640**
**Phone (573) 330-0732 Fax (573) 218-0716**
**mineralareapsychiatricservices@outlook.com**

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**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 Conditons:** _____

**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