



2009 Patient Information Form

Today's Date _____

Please fill out BOTH sides of form

Patient Name: _____ Male Female
(First) (Middle) (Last)

Street Address City State Zip Code

Home Phone Work Phone Cell Phone

*Patient's SSN. Patient's DOB: _____

Patient's Status: check all that apply Single Married Other Employed Student full or part

Patient Employer/School Phone# _____

Who referred you here: May we send a thank you letter? Yes No
May we leave a message at your home with other residents? Yes No On your voice mail? Yes No

Who may we talk to about your medical concerns _____

Is this contact for emergency purposes only? Yes No Relationship _____

For MINORS:

Child lives with Both Parents Mother Father Other _____

Mother: Address (if different) _____

DOB Home Phone Work Phone _____

Employer: SSN: _____

Father: Address (if different) _____

DOB Home Phone Work Phone _____

Employer: SSN: _____

Name of parent responsible for the minor child's appointment _____

INSURANCE INFORMATION

Primary Insurance Co: ID# on card Group# _____

Policyholder DOB SS#
(First) (Middle) (Last)

Place of employment _____

Patient's Relationship to Insured Party: Self Spouse Dependent Card Copied Yes No

Secondary Insurance Co: ID# on card Group# _____

Policyholder DOB SS#
(First) (Middle) (Last)

Place of employment _____

Patient's Relationship to Insured Party: Self Spouse Dependent Card Copied Yes No

Identification of other physicians/healthcare providers involved with my medical care whom I authorize ongoing release of information for continuity of care

Primary Care Physician _____ Phone _____

Address _____

Referring Doctor(if different) _____ Phone _____

Address _____

Consent for Treatment and Consultation and Payment of Services

By my signature below I authorize the staff of "Key Life Directions/Jill M. Fox, M.D." to provide services to my minor child or me. This authorizes the **INSURANCE CARRIER** to make checks for medical expenses due me under this payable to "**The Above Named Practice.**" I realize that this may not represent the full payment and I am ultimately responsible for the balance due. I authorize "**The Above Named Practice**" to release any information regarding treatment of me and/ or my minor child to the **INSURANCE CARRIER** and the above named.

Patient or Parent Signature _____ Date: _____

Key Life Directions Policies

Please review the following and **sign.**

Confidentiality

Therapeutic relationship is based on confidentiality. Neither the therapist/psychiatrist nor any employee will divulge information about any patient without written consent w/ the following exceptions:

1. When required by the individual's insurance company
2. Information will be provided to the referring physician, when applicable
3. When it is felt that the patient is a danger to himself or to others.

Fees

You will be charged 50% of session fee for any missed appointment, unless this office is notified at least 24 hours prior to your set appointment time. This is necessary because there is usually someone waiting to be scheduled, someone who could have used that time slot we reserved for you. Your insurance company will NOT allow us to bill them for any missed appointments. Therefore you will be billed directly for this fee and you alone will be responsible for paying this fee.

Payments

We bill your insurance company as a courtesy to you. It is required that you understand your policy. Prior to your first session, you should be aware of the # of yearly sessions allowed, your co-payment and any yearly deductible.

We will do our best to **estimate** the amount you owe at time of service. We reserve the right to reschedule your appointment if you do not have your payment.

*When you also see another mental health provider outside this office. There may be additional authorization requirements or visit number limitations. (Benefits often are shared)

It is your responsibility to keep this office informed of any changes to your insurance coverage.

*Failure to do so will result in you being financially responsible for any denied claims.

Outstanding balances will be handled with a payment plan. Accounts over 90 days without a payment plan will be sent to a collection agency.

***In case of a divorce**, the parent of guardian who is bring the child in for services will be held responsible for payment regardless of a divorce decree.

Your signature below will indicate your understanding of our policies and your agreement to pay for services rendered. If you have questions, please don't hesitate to ask us.

Patient and/or Guardian Date _____

Witness Date _____

HIPPA

By my signature below I acknowledge the posting of Key's HIPPA Privacy Notice and/or receipt (if requested) of such notice in writing.

Patient or Parent Signature: _____ Date: _____

***NOTE: IT IS IMPORTANT THAT WE HAVE COMPLETE INFORMATION FOR BILLING PURPOSES. IF YOU DO NOT HAVE THIS INFORMATION WHEN YOU ARRIVE, PLEASE CALL US WITH THE INFORMATION AS SOON AS POSSIBLE. FAILURE TO HAVE YOUR REFERRAL IN PLACE AT TIME OF VISIT MAY NECESSITATE RESCHEDULING.**