**CHILD/ADOLESCENT ESTABLISHED PATIENT PACKET**

WAKE PSYCHIATRY

PATIENT INFORMATION DOCTOR:_____

DATE:____/____/____ SS # _____-_____-_____ DOB:____ /____ /_____

NAME:_____
(last) (first) (middle)

ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

PHONE (HOME):_____ (CELL):_____

EMAIL:_____ GENDER: M F Marital Status _____

APPOINTMENT REMINDER PREFERENCE: ( ) TEXT ( ) EMAIL

INSURANCE COVERAGE

PATIENT NAME:_____

INSURANCE COMPANY_____

CUSTOMER SERVICE PHONE#:_____

MENTAL HEALTH PHONE# (IF DIFFERENT): _____

POLICY HOLDER (SUBSCRIBER) NAME:_____

RELATIONSHIP TO PATIENT: _____

POLICY HOLDER (SUBSCRIBER) ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

POLICY HOLDER DOB: ____ / ___ _____ POLICY HOLDER SS#_____-____-_____

SUBSCRIBER ID#_____ GROUP#_____

***Please note that we file with primary insurance only. Our office does not file out-of-network or secondary insurance claims.***

# Wake Psychiatry, PLLC
## Financial Policy

Thank you for choosing Wake Psychiatry for your psychiatric care. We are committed to providing the highest quality of treatment. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy. Please read and sign prior to your first appointment.

Full payment is due at the time of service. We accept cash, check, Visa or MasterCard.

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.

Our practice is committed to providing the best treatment for our patients and we charge the usual and customary rate for our area. You are responsible for payment for services rendered regardless of any determination made by an insurance company of usual and customary rates or non-charges.

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 calls and/or emails are considered only a courtesy. You are ultimately responsible for keeping a record of the day and time of your appointment.

Each visit, you will receive a receipt which will show whether there is a balance on your account. Insurance carriers sometimes take a while to collect. The office staff will notify you if there is a balance due that is your responsibility.

Please let us know if you have any questions or concerns.

I have read the policy and agree to the terms.

_____ _____

Signature of Patient or Guardian Date

## Notice of Privacy Practices

Our Notice of Privacy Practices may be found on our website at www.wakepsychiatry.com. You may also obtain a copy of this notice from our office staff. By signing below, you acknowledge receipt of this notice. You may refuse to sign this acknowledgement. Please understand that should you refuse to sign, Wake Psychiatry, PLLC will not be able to file to your insurance and you would be fully responsible for all charges.

I,_____, have read or received a copy of this office's Notice of Privacy Practices.

_____

Signature

_____

Printed Name

_____

Date