PSYCHIATRIC SERVICES, P.C.

Robert Dale Jones, M.D. emeritus
Sarah L. Jones, M.D. emeritus
Michael J. Sedlacek, M.D.
Janet P. McGivern, M.D.
Cheryl J. Buda, M.D.
Brian Lubberstedt, M.D.
Julie A. Dickson, M.D.
Spencer M. Gallner, M.D.
Todd K. McKee, Ph.D.

CENTER POINTE BUILDING
9239 W. Center Road, Suite 211
Omaha, NE 68124-1900

Telephone: (402) 399-9305
Fax: (402) 397-3191
www.psychiatricservicespc.com

Dear_______________________________

Your appointment information:

Date:_______________________________

Time:_______________________________

Physician:___________________________

Welcome to Psychiatric Services, PC. We appreciate that you have selected our practice to provide your medical services. The relationship between physician and a patient is very important: we have designed every aspect of our practice to provide the best care possible.

Enclosed you will find pre-registration and medical history forms as well as other vital information. To expedite your first visit we ask that you complete all of the forms **prior** to your first visit, arrive 15 minutes early to allow enough time to ensure forms are complete, scan your medical insurance card and take a quick picture for your chart. Please be sure to list all your medications on the attached sheet. If you have any questions regarding these forms do not hesitate to contact our office.

If you for any reason are unable to keep your appointment, please contact our office at 402-399-9305 to reschedule your appointment.

Sincerely,

The Physicians and Staff of Psychiatric Services, PC.

PSYCHIATRIC SERVICES, P.C.

FORMS CAN BE COMPLETED ON OUR WEBSITE **www.psychiatricservicespc.com**

Where options are listed please **circle only one answer**.

Date of Appointment	**Reason for Appointment**	**Appointment With** O Sedlacek / O McGivern / O Buda / O Lubberstedt / O Dickson / O Gallner / O McKee

Referring Physician	**Family Physician (if different than Referring Dr)**

Pharmacy Name	**Pharmacy Address, City, State, Zip Code**	**Pharmacy Phone #**

Patient's Name: First Name, Middle Initial, Last Name (please print) Goes By	**Sex** O M / O F	**Date of Birth**	**Age**	**Soc. Sec. #**

Race: White-Caucasian O Black-African-American O American Indian-Alaska Native O Asian O Nat. Hawaiian-Pacific Islander O Declined O Unknown O Other:____________________

Ethnicity: Declined O Hispanic-Latino O Not Hispanic-Latino O

Primary Language: English O Spanish O Arabic O Chinese O Filipino O French O German O Greek O Hindi O Hmong O Italian O Japanese O Korean O Lithuanian O Polish O Portuguese O Russian O Somali O Vietnamese O Declined O N/A O Other:____________________

Religion: Buddhist O Catholic O Hindu O Islam O Jehovah's Witness O Jewish O Mormon O Protestant-Methodist O Lutheran O Baptist O N/A O Unknown O

Marital Status: Single O Married O Separated O Divorced O Widowed O Annulled O Common Law O Domestic Partner O Living Together O Other O

Street Address (include apt#)	**City, State and Zip Code +4 digits**

Home Phone #	**Work Phone # (include ext.)**	**Cell Phone #**	**Primary Phone #** Home O Work O Cell O

Fax #	**Pager #**	**Email Address**

EMPLOYMENT INFORMATION

Patient's Employer	**Status:** Full-time O Part-time O Self-employed O Retired O Unemployed O Temporary Unemployed O Leave of Absence O Contract O Active Military Duty O Part-time Student O Full-time Student O Other O

Employer's Street Address	**City, State and Zip Code**	**Occupation (indicate if student)**

EMERGENCY CONTACT INFORMATION

1st Emergency Contact (First Name, M.I., Last Name)	**Relationship**	**Date of Birth**	**Cell Phone #**
Emergency Contact's Employer	**Occupation (indicate if student)**		**Work Phone #**

2nd Emergency Contact (First Name, M.I., Last Name)	**Relationship**	**Date of Birth**	**Cell Phone #**

INSURANCE INFORMATION

Person Responsible for Payment (if not the patient)	**Street Address, City, State and Zip Code**		
Primary Insurance	**Policyholder's Name**	**Relationship**	**Date of Birth**
Secondary Insurance	**Policyholder's Name**	**Relationship**	**Date of Birth**

ALL INSURANCE COPAYS ARE TO BE PAID AT TIME OF SERVICE.

All professional service rendered are charged to the patient. Our office will complete the necessary forms to help expedite insurance payments. However, the patient is responsible for all fees regardless of insurance coverage including denied or non-covered services by Medicare, Medicaid and Medicaid Managed Care Plans.

INSURANCE AUTHORIZATION AND ASSIGNMENT

Name of Policyholder____

I hereby assign payment directly to Psychiatric Services PC any medical benefits for professional services rendered. I understand that I am financially responsible for my deductible, coinsurance, copayments, services received without prior authorization and any allowable charges by my insurance company/companies. I also authorize the release of information to another physician, hospital or insurance company as may be necessary for further treatment or determination of benefits and payments.

Patient Signature **X** ____________________________________ Date ________________________

Personal Representative Signature **X** ____________________________ Date ________________________

Relationship to Patient____

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TREATMENT AGREEMENT

- I consent to the care and treatment for myself with Drs. Sedlacek, McGivern, Buda, Lubberstedt, Dickson, Gallner, McKee and their associates.
- I understand that I am financially responsible for all charges incurred for the services received from the above providers, regardless of insurance coverage. This includes, but is not limited to charges that are denied for pre-existing conditions, usual and customary allowances, and charges not allowed / covered by the insurer. Because of the growing number of different insurance policies, it is my responsibility to check and become familiar with my mental health benefits. Furthermore, if my managed care plan requires precertification, I realize it is my responsibility to precertify my first visit and present my authorization number at the time of my first visit. I understand the business office will cooperate with my insurance company, but that it is my responsibility to contact my insurance carrier to meet any additional requirements for pre-certifications that are not listed above.
- I have been informed that my insurance company may request copies of my medical records be faxed in order to make payment or authorize further visits. My signature below gives my permission to release this information and to fax medical records when requested.
- I understand the physician/therapist cannot render services on my behalf on the assumption that the charges will be paid by my insurance carrier. I further understand that in the event of non-payment by my insurance carrier for any reason I agree to be personally responsible for the balance. In the event of non-payment, my account may be assigned or referred to a collection agency for collections.
- I understand and agree to the terms of the Credit Policy as outlined below:
  Payment is expected in full within 30 days from your statement date. Limited exceptions may be allowed but only if prearranged. My copayment, coinsurance and any deductible is expected at the time of service.
- I am aware that the effectiveness of the treatment reviewed with me depends upon my commitment to the program and follow through with scheduled appointments. If I do not give 24 hours notice of cancellation there will be a charge for that missed appointment. Also, if repeated appointments are missed this may result in termination of care from this office and/or referral to another provider.
- I agree to provide timely notification to Psychiatric Services, PC of any changes in address, guarantor status, employment, and insurance coverage.
- I understand that I may use my VISA, Mastercard, Discover, American Express or bank debit card to pay for my services.
- I understand it may be necessary from time to time for the office to contact me by telephone. If I cannot be reached, I understand the office policy is to leave a discreet message on my answering machine or voice mail, or with whomever answers the telephone on my behalf. I agree to hold the office harmless for all such disclosures in compliance with this policy.
- No recording of any patient sessions shall be allowed and no recording devices of any kind shall be brought by a patient to a session.
- My signature below indicates I have read and fully understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization.

____

Signature of Patient and/or legal guardian

Date ______________________ Witness ______________________

CONSENT TO RELEASE INFORMATION TO PRIMARY CARE PHYSICIAN

Patient Name: ______________________________ DOB: ______________________

Address: ____

I hereby

______ Do

______ Do NOT

give my informed consent for (please circle)

Janet P. McGivern, M.D. O	Michael J. Sedlacek, M.D. O
Cheryl J. Buda, M.D. O	Brian Lubberstedt, M.D. O
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Todd K. McKee, Ph.D. O	

regarding my treatment to speak with or send documentation to my

Primary Care Physician ______________________________
Name

____
Street Address

____
Telephone Number Fax Number

I understand my records are protected under Federal Regulation 42 CFR, Confidentiality of Alcohol and Drug abuse and under the general laws of my state. They cannot be re-disclosed without my written consent, except as specially stated by law.

I understand I am authorizing the release of confidential information which is to be used in conjunction with the profession services I am receiving.

I understand this authorization shall remain in effect until otherwise withdrawn or cancelled by me in writing. A copy of this authorization is as good as the original.

Signature ______________________________ Date ______________________

Witness ______________________

Name ______________________________ Date ______________

FAMILY HISTORY

Spouse Name ______________________________ Years Married ______________

Children's Names and Ages ______________________________

____

Were you raised by: Both Parents? __________ Single Parent? __________ Relative? __________ Other? __________

Father's Name/Occupation ______________________________

Mother's Name/Occupation ______________________________

Brothers/Sisters in birth order: (Include Ages) ______________________________

Family History of: (who, what)

Alcoholism or Substance Abuse? ______________________________

Mental Illness? ______________________________

Prolonged Physical Illness? ______________________________

Your Education: Highest Degree: ______________ Field of Study: ______________

I, or ______________________, will be responsible for any charges for evaluation or treatment by Drs. Michael J. Sedlacek, Janet P. McGivern, Cheryl J. Buda, Brian Lubberstedt, Julie A. Dickson, Spencer M. Gallner, Todd K. McKee, and his/her associates in this office. I understand that I am responsible for payment for consultation not canceled 24 hours in advance. I understand that payment if charges incurred is due at the time of service, unless other definite financial arrangements have been made prior to treatment. I hereby authorize the clinician to furnish information to insurance carriers concerning my treatment. I understand that I am responsible for all payments. Any monies received by the clinician from above insurance companies, over and above my indebtedness, will be refunded to me when my bill is paid in full. I understand any returned checks will subject me to a $25.00 returned check charge.

I have read and fully understand the above consent for treatment, financial responsibility, release of medical information, and insurance authorization.

Patient's Signature ______________________________ Date ______________

Parent/Guardian's Signature ______________________________ Date ______________

We will be happy to file your insurance claim, but your co-payment and/or your portion of the bill is expected at the time of service. We will be happy to discuss fees, schedule of payment, or any other question relating to billing or insurance.

ACKNOWLEDGEMENT OF PRIVACY NOTICE

The undersigned hereby acknowledges receipt of the Notice of Privacy Practices of Psychiatric Services, PC.

Signature ______________________________ Date ______________

Print name ______________________________