RALEIGH PSYCHIATRIC ASSOCIATES
PATIENT INFORMATION SHEET

Page 1 DATE_____

PLEASE PRINT CLEARLY:

PATIENT NAME_____
LAST FIRST MIDDLE MAIDEN NAME

ADDRESS_____
STREET CITY STATE ZIP CODE

SOCIAL SECURITY NUMBER_____ SEX: M___ F___ AGE___ DATE OF BIRTH_____

OCCUPATION_____ EMPLOYER_____

HOME PHONE #_____ BUSINESS PHONE #_____ CELL PHONE # _____

MARITAL STATUS: SINGLE__ MARRIED__ WIDOWED__ DIVORCED__ SEPARATED__ OTHER____

SPOUSE OR PARENT: _____
(Indicate which) NAME ADDRESS (If different) PHONE

_____
INSURED'S DATE OF BIRTH OCCUPATION EMPLOYER BUSINESS PHONE

CHILDREN OR SIBLINGS:_____
(Indicate which)
PLEASE INCLUDE NAMES_____

AND AGES _____

PRIMARY PHARMACY_____ PHONE NUMBER_____

REFERRED BY_____PRIMARY PHYSICIAN_____

Letter can be sent to referring clinician: Yes_____ No_____

PERSON TO NOTIFY IN CASE OF EMERGENCY:_____

_____
PHONE NUMBER RELATIONSHIP

PSYCHIATRIC CONTACT WITH MENTAL HEALTH PERSONS, PSYCHOLOGISTS, PSYCHIATRISTS,

SOCIAL WORKERS, COUNSELORS OR HOSPITALIZATIONS: _____

_____

_____

_____

Implemented 7/04

PLEASE COMPLETE REVERSE

PERSON RESPONSIBLE FOR BILL_____
IF OTHER THAN PATIENT: NAME RELATIONSHIP

_____
STREET CITY STATE ZIP CODE

NAME OF HEALTH INSURANCE_____

NAME OF INSURED_____ INSURED'S DOB _____

CERTIFICATE NUMBER_____ GROUP NUMBER_____ EFFECTIVE DATE_____

PRE-CERTIFICATION NUMBER:_____ NUMBER OF VISITS:_____

I agree to be responsible for all medical expenses incurred at Raleigh Psychiatric Associates regardless of what my insurance carrier decides or reimburses. In any overpayment on my account, a refund will be issued to me.

I authorize the physician or therapist to provide treatment as is necessary. Additionally, I authorize the release of medical information to my insurance carriers. I authorize release of medical information to my primary physician.

I understand that Raleigh Psychiatric Associates (RPA) is an interdisciplinary group practice in which clinicians share medical records and on-call responsibilities. I understand that my clinician may recommend the services of another RPA clinician to collaborate, consult and/or coordinate with my care. I understand that in so doing, clinicians may need to share information about me.

The clinicians and staff at Raleigh Psychiatric Associates do not, as a routine, accept E-mails. Each clinician may choose to make an acceptation to this policy with a particular patient. Should this occur, then there will be an agreement signed by both patient and clinician that acknowledges this arrangement and it will be a part of the clinical record along with copies of all the E-mails.

I understand that if I do not give <u>24 Hour Notice</u> for cancellation of appointment I will be charged a regular fee.

_____ _____
Patient Signature Date

I authorize my insurance benefits to be paid directly to the designated physician or therapist.

_____ _____
Patient Signature Date