Aiken Psychiatric and Psychotherapy Associates, P.A.
33 Varden Drive, Aiken, South Carolina 29803
(803) 642-3801

Patient Information

Name:_____ Date:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone: HOME_____CELL_____WORK_____

Appointment Reminder: Phone Call **or** Text Message _____
(Please circle your preference of reminder and add the best contact number.)

Email Address:_____

SSN:_____ DOB:_____ SEX: M__ or F__

Spouse's Name:_____

Financial Responsibility

Person Responsible For Payment: _____

Address: _____

City:_____ State: _____ Zip: _____

Phone: HOME_____ CELL_____ WORK_____

SSN: _____ DOB: _____

Emergency Contact

Name:_____ Relationship: _____

Address: _____

City:_____ State: _____ Zip:_____

Phone: HOME _____ CELL _____ WORK_____

Insurance Information (Please, fill in completely and have your insurance card and Identification present)

Primary Carrier: _____ Phone: _____

Claims Address: _____

Policy # _____ Group # _____

Please, list any secondary insurance information in the space below.

_____

_____

_____

Pharmacy and Medication(s)

Preferred Pharmacy: _____

Address: _____

Phone Number: _____

Do You Have Any Known Allergies: No __ Yes __If yes, please, list: _____

_____

Current Medications You Are Prescribed Including Name and Dosing Information:

Medication:_____ Dosing Info:_____

Medication:_____ Dosing Info:_____

Medication:_____ Dosing Info:_____

Medication:_____ Dosing Info:_____

Medication:_____ Dosing Info:_____

Medication:_____ Dosing Info:_____

Medication:_____ Dosing Info:_____

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Welcome to Aiken Psychiatric and Psychotherapy Associates, P.A. We appreciate the opportunity to serve you. You will be required to read and sign this agreement prior to any treatment.

We require that all co-pays, co-insurance, and deductibles be paid at the time of service. We accept cash, checks, Visa and Mastercard. If you do not have insurance, the full amount of your bill is due at the time of service. There will be a $35.00 fee charged on all returned checks.

We are providers of Medicare. Unless there is a secondary insurance that Medicare automatically transfers, you will be expected to pay your co-pay at the time of your visit. We will file secondary insurance.

We file primary insurance as a *courtesy* to our patients. In order to do so, we must be provided with all correct insurance information to include a copy of your current insurance card. You are responsible for making us aware of any changes to your insurance and must provide us with updated card(s). Please, be aware that if this is not done in a timely manner you may incur charges that will become your responsibility and that patient balance must be paid in full. You are also responsible for any amount not covered by your insurance company. We are committed to providing the best quality care for our patients and we charge what is customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

When fees for services are not paid in a timely manner, collection agencies may be utilized in collecting unpaid debt. This is done only after a reasonable effort has been made on our part to collect the debt. You understand by signing this document that identity may be released in this case causing your confidentiality as a patient of this practice to be breached.

We reserve the right to charge for appointments that are missed or are cancelled without 24 hours notice. Please, help us to serve your better by keeping all scheduled appointments. After three missed appointments, without proper notice or explanation, you may be terminated from the practice.

Any unpaid balances on your account may cause a delay in your follow up appointment until it is resolved. Medications may not be refilled if appointments are not attended. Please, allow 24 hours for medication request to be processed.

If you are late to an appointment, you may be asked to reschedule.

Make yourself aware of your insurance coverage during telehealth visits, as well. You are responsible for calling to make payments even if you do not come to the office in person.

Should you have any questions or if for any reason you cannot comply with these requests, please, notify the front desk immediately so that other arrangements can be made.

Thank you again for choosing Aiken Psychiatric and Psychotherapy Associates, P.A.

I HAVE READ THE INFORMATION ABOVE AND FULLY UNDERSTAND MY OBLIGATION TO THE PRACTICE AND AM IN AGREEMENT WITH THIS POLICY.

_____ _____

RESPONSIBLE PARTY **DATE**

Revision 06/2023

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Acknowledgment of Medical Practice

As a patient at this practice, you will be seen by a medical professional. That medical professional must subscribe to a body of ethical standards, primarily for the benefit of you, the patient. The medical professional must recognize their responsibility not only to patients but to society, to other health professionals and themselves. The following is the standard of conduct which defines the essentials of honorable behavior for a physician:

1. A physician must be dedicated to providing competent medical services with compassion and respect for human dignity.

2. A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficit in character or competence, or who engage in fraud or deception. Sexual harassment of patient or staff, or sexual activity between staff and patient or their family members is unethical, will not be tolerated and should be reported to our practice administrator, **Mrs. Dannette Rowe**, immediately.

3. A physician shall respect the laws and also recognize a responsibility to seek changes in those requirements that are contrary to the best interest of their patients.

4. A physician shall respect the laws and also recognize a responsibility to seek changes in those requirements that are contrary to the best interest of their patients.

5. A physician shall continue to study, apply an advanced scientific knowledge, make relevant information available to patients, colleagues, and the public, obtain consultation, and the use of the talents of other health professionals when indicated.

6. A physician shall, in the provision of appropriate patient care, except in emergency, be free to choose whom to serve, with who to associate, and the environment in which to provide medical services.

7. A physician shall recognize their responsibility to participate in activities contribution to an improved community.

Patient Acknowledgement Signature _____

Date_____

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Informed Consent for Treatment

You, as the patient, voluntarily agree to take part in treatment at Aiken Psychiatric and Psychotherapy Associates, P.A. This may include but not limited to the following services: psychiatric evaluation, consultation, individual, couple, adolescent and/or family therapy.

You, as an informed patient, are encouraged to be active in the treatment process by sharing both your questions and thoughts as well as following treatment recommendations. There are no guarantees of results in psychiatric or psychotherapy care but it is our belief that active involvement increases chances of an improved outcome. You may terminate treatment at any time with any of our clinical professionals.

Because your mental health is important to us and we realize you may have a crisis after business hours, your psychiatrist and/or psychotherapist uses an on-call system for emergencies which is manned by our clinical staff and other highly trained, licensed individuals in our community. Our office number will put you in touch with one of these skilled professionals.

It is sometimes required by your insurance carrier that an official supervisory relationship is maintained between David Steiner, M.D. and your provider. In keeping with general accepted standards of practice, consultation may occur with other psychiatrists, nurse practitioners or psychotherapists to assure quality of care. In such cases, the name of the client or any identifying information is not discussed, only clinical information.

Neither verbal or written information about a patient cannot be shared with another party without the written consent of the patient or the patient's legal guardian with noted exceptions below:
*Imminent danger to self or others is addressed through appropriate treatment and warning others is needed.
*Child, disabled, or elderly abuse is reported to the appropriate authorities.
*Information legitimately ordered by a court of law is provided to that court.
*Information from the records will be given to parents or legal guardians of non-emancipated minor patients on occasion.
*In some case, notes, reports, and correspondence are dictated, typed, filed and handled within the office or by outside sources (such as billing)but all are held accountable for such procedures.
*If a medical or psychiatric emergency does arise, we will attempt to inform the individual you designated as your emergency contact. We will also provide necessary information to medical professionals to expedite and improve your care.

Each of the clinical professionals within this practice are licensed in their respective fields. We expect our professionals to maintain a high standard of professional care and follow the code of ethics of their profession.

I have read the Informed Consent for Treatment and understand the preceding information.

Signature of Client (or person acting for client)	**Date**
Printed Name	**Relationship of Client**

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Health Insurance Portability and Accountability Act of 1996 (HIPAA)

This form is an agreement between you, _____ and Aiken Psychiatric and Psychotherapy Associates, P.A. When we use the word "you" below, it will mean your child, relative, or other person if you have written his/her name here: _____

When we examine, diagnose, treat or refer you, we will be collecting what the law calls, **Protected Health Information (PHI)** about you. We need to use this information to decide what treatment is best for you and to provide treatment to you. We may also share this information with others who provide treatment to you or need the information to arrange payment for your treatment or for other business or government functions.

By signing this form you are agreeing to let us use your information at Aiken Psychiatric and Psychotherapy Associates, P.A. and send to others. Aiken Psychiatric and Psychotherapy Associates, P.A. will seek to obtain written permission from you first. The **Notice of Privacy Practices** explains in more detail your rights and how we can use and share your information. Please, read the **Notice of Privacy Practices** before you sign this consent form.

If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices, we cannot treat you.

In the future, we may be required to change how we use and share your information and thereupon change our Notice of Privacy Practices. If we do change the NPP during your treatment, you will be notified.

When this office needs to contact you regarding scheduling or cancelling an appointment, please, let us know which you'd prefer us to do by checking below:

_____Call you on your home or cell phone and leave a voice message, if available, using this phone number: _____HOME or CELL

_____Call you at work at this number:_____

_____Other person you designate to receive scheduling information.
Name:_____Relationship:_____
Phone number: _____

If you are concerned about your information, you have the right to ask us to not use or share some of your information for treatment, payment, or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we promise to comply with your wishes.

After you have signed this consent, you have the right to revoke it by writing a signed letter telling us you no longer consent and we will comply with your wishes about using or sharing your information from that time on. We may have already used or shared some of your information, for example, billing your insurance company and cannot change that.

_____	_____
Signature of client or his/her personal representative	Date
_____	_____
Printed name of client or personal representative	Relationship to client
_____	_____
Witness	Date

Initial here _____ if you received a copy of the Notice of Privacy Practice.

Initials of staff_____

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Notice of Privacy Practices: Your rights regarding your health information

You can specify how we communicate with you about your health and related issues. For example, you can ask us to call you at home and not at work to schedule or cancel an appointment.

You have the right to ask us to limit what we tell people involved in your care or the payment for your care such as insurance companies, health and/or social service providers.

You have the right to review the health information we have such as your medical and billing records with a professional within the office.

If you believe the information in your record is incorrect, missing important information or you disagree with your medical record, please, make a request in writing and send it to the office's privacy official, Dannette Rowe. You must tell them the reason(s) you want to make the changes.

This copy of this notice now belongs to you. If we change this notice of privacy practices, we will post a new version in our waiting area. You may get a copy of the current document from the privacy official.

You have the right to file a complaint if you believe your privacy rights have been violated. You may file a complaint with our privacy official and with the Secretary of the Department of Health and Human Services. All complaints must be in writing.

If you have any questions regarding this notice or our health information privacy policies, please contact our privacy official at 803-642-3801.

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Patient Responsibilities

Patients, please, initial each of the following.

_____All copayments, deductibles, and balances must be paid at the time of in-office visits.

_____All copayments, deductibles, and balances must be paid before telehealth appointments. You may call the office to make the payment.

_____It is your responsibility to ensure all future appointments are scheduled.

_____Cancellations need to be made at least 24 hours in advance of your scheduled appointment. You may incur a fee for a failed appointment if we are not notified in that time frame.

_____If you miss two appointments, all standing future appointments will be removed.

_____Our automated service will attempt to call or text you two days in advance to remind you of your upcoming appointments. Remember, this is a courtesy call. You are still responsible for your appointment regardless if you receive the reminder or not. It is always a good idea to have staff print out an appointment card for you to keep.

_____The after-hours answering service is for EMERGENCIES ONLY and will not accept routine calls for prescription refills and appointment cancellations.

_____Because there is a 24 hour BUSINESS HOUR turn around for prescription refill requests, it is not in your best interest to wait until you are down to your last pill or at end of the day on Friday or a Holiday.

_____If you are late to an appointment, you may be asked to reschedule.