INTEGRATIVE PSYCHIATRY AND WELLNESS

PATIENT REGISTRATION

Thank you for selecting our healthcare team! We will strive to provide you with the best possible healthcare. To help us meet all your needs, please fill out this form completely. Please ask if you need assistance and we will be happy to help.

PERSONAL INFORMATION:

Name: _____ Date: _____

Address: _____ Birth Date: _____

City: _____ State: _____ Zip: _____ Soc. Sec. #: _____

Home Phone: _____ Work: _____ Cell: _____

Permission to be called: _____ or Emailed: _____

Male ___ Female ___ Minor ___ Single ___ Married ___ Divorced ___ Widowed ___ Separated ___

Employer: _____

Address: _____

Referred By: _____

RESPONSIBLE PARTY: ***Who is responsible for this account?***

Name: _____ Relationship to client: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Emergency Contact:

Name and relation: _____Phone: _____

Preferred Pharmacy: _____ Phone: _____

Legal Responsible Party for Consent of Treatment:

Name: _____ Date: _____

Patient/Guardian Signature: _____

4901 E. Dry Creek Road, Suite 130 ● Centennial, CO 80122 ● 303.694.0698 Phone ● 303.694.0411 Fax
integrativepsychiatryandwellness.com

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POLICY ACKNOWLEDGEMENT

Please read and initial all blanks below

1) ____ All appointments must be cancelled 48 hours prior to appointment time or the patient will be charged.
2) ____ Only exception that will not be charged are illness or emergencies.
3) ____ May require documentation if missed appointments become excessive.
4) ____ Patients will not be seen if arriving 15 min late. Patient will be charged and must reschedule.
5) ____ All active patients must have credit card on file, prepay on day of scheduling or make prearrangements prior to appointment.
6) ____ Patient agrees to follow the treatment plan and see Provider a minimum of every three (3) months, or as directed by Provider to stay compliant as a Patient. If noncompliant, patient may be discharged.
7) ____ Please reschedule if you are/were unable to make your scheduled appointment.
8) ____ Not rescheduling in a timely manner may delay medication refills until scheduled.
9) ____ Please notify your pharmacy at least 48 hours in advance of ALL prescription medication refills.
10) ____ All handwritten prescriptions must be called in to our office at least one (1) week prior to picking up.
11) ____ We are unable to refill prescriptions after 3 PM on Thursdays through Monday, as our office is normally closed.
12) ____ Please call 911 for all emergencies as we are not an urgent care or emergency clinic.
13) ____ Please ensure you will notify us of new contact information such as phone numbers, email and address. If we are unable to reach you this is not an excuse for non-compliancy.
14) ____ Please allow seven (7) business days for requests that include letters, treatment plan summaries, etc. Patient will be charged hourly rate for any requested written information.

I have read, understand and agree with the requirements stated above:

Patient/Guardian Signature: _____ Date: _____

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Acknowledgement of Receipt of Notice of Privacy Practices

By my signature below I, _____,

(print your name above)

acknowledge that I received a copy of the Notice of Privacy Practices for Integrative Psychiatry and Wellness.

Signature of Patient or Personal Representative: _____

Date: _____

If this acknowledgement is signed by a personal representative on behalf of the patient, complete the following:

Patient's Name: _____

Personal Representative's Name: _____

Relationship to Patient: _____

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INTEGRATIVE PSYCHIATRY AND WELLNESS

Informed Consent for Telemedicine Services

Under special circumstances our providers may be able to provide you with telemedicine services. This means that your healthcare provider can interact with you through video connection, email or phone, to consult with you about your condition. By signing this consent form you are authorizing this communication to take place should it be approved by your healthcare provider. Our providers are only able to offer this under special circumstances that must be discussed with the provider and approved by them directly prior to the appointment. **Any communication via phone outside normal business hours will be prorated the hourly rate with a minimum fee of $45.** This authorization does not guarantee you the offering of these services.

Potential risks of technology:

- The video/phone connection may not work or may stop working during the consultation.
- The video picture of information transmitted may not be clear enough to be useful for the consultation.
- I may be required to go to the location of the healthcare provider if it is felt that the information obtained via telemedicine was not sufficient enough to allow for appropriate medical decision making.
- In very rare instances, security protocol could fail, causing a breach of privacy and personal medical information.
- Emails should contain as little information as possible and will be sent at your own risk.

By signing this form I understand the following:

- I understand that the laws that protect privacy and confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researcher or other entities without my consent.
- I understand I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.
- I understand other individuals may be present to operate the video equipment and that they will take reasonable steps to maintain confidentiality of the information obtained.
- I understand that I will be charged for the full amount of the scheduled conference. I have read this document and understand the risks and benefits of telemedicine. I hereby consent to participate on a telemedicine visit under the conditions described in this document.
- I hereby authorize **Lisa Trochmann** to use telemedicine in the course of my diagnosis and treatment, should my healthcare provider feel it is appropriate and necessary.
- Any telemedicine sessions must be arranged in advance, and not as a result of not being able to physically attend their scheduled appointment.

All communication via TEXT MESSAGE is PROHIBITED

Signature of Patient/Legal Guardian: _____ Date: _____

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INTEGRATIVE PSYCHIATRY AND WELLNESS

Credit Card Authorization

I, _____,
authorize Integrative Psychiatry and Wellness to keep my credit card number on file along with information needed to process a sale, and charge my card each time the following patient receives services or purchases supplements in the office.

Patient Name: _____

Relationship to Patient: _____

Credit Card Information:

Name as it appears on the Card:

_____

Type of Card: □ VISA □ MASTERCARD □ DISCOVER □ AMERICAN EXPRESS

Credit Card Number_____- _____-_____- _____ Expiration Date_____/_____

3 or 4 Digit Security Code: _____

Credit Card Billing Address:

Street: _____

City: _____State: _____Zip Code: _____

Telephone: _____

- I understand the that above card will be automatically charged for any missed appointment, or an appointment not cancelled at least 48 hours in advance per Integrative Psychiatry and Wellness' Policy
- I understand that I may revoke this authorization at any time by written notification to Integrative Psychiatry and Wellness. This authorization will be in effect until the card's expiration (listed above) or until revoked by the cardholder, whichever comes first.
- I certify that I am the authorized signer for this card.

Cardholder Signature: _____

Date: _____/_____/_____