



Patient's Legal Name (First, MI, Last): _____

Preferred Name: _____

Cell Phone Number: _____ Home Phone Number: _____

Can We Leave A Message with the Patient's Cell/Home Phone Number: Yes or No

Email Address: _____

- Yes, please sign me up to receive both email and text messaging appointment reminders/confirmations
- I do not wish to receive appointment reminders by either e-mail or text messaging

Date of Birth: _____ Social Security Number: _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Marital Status: Married Single Divorced Widowed

Sex: Male Female Other

PHARMACY INFORMATION:

Pharmacy: _____ Pharmacy Phone Number: _____

Pharmacy Address: _____

City: _____ State: _____ Zip: _____

INSURANCE INFORMATION:

1. Primary Insurance: _____ Patient is Subscriber/Policy Holder: Yes or No

2. Secondary Insurance: _____ Patient is Subscriber/Policy Holder: Yes or No

PRIMARY INSURANCE HOLDER INFORMATION (if other than patient):

Policy Holder Name: _____ Relationship to patient: _____

Date of Birth: _____

EMERGENCY CONTACT INFORMATION:

For safety purposes, we require at least one emergency contact.

1. Name: _____ Relationship to you: _____

Phone Number: _____

2. Name: _____ Relationship to you: _____

Phone Number: _____

Release of Protected Health Information (PHI)

Per HIPAA guidelines you must give permission before any information can be released to anyone other than yourself or your legal guardian.

Please list below the name(s) and relationship of any family/friends who may have access to your PHI on record at our office. This includes prescriptions refills, appointment times, diagnosis, office chart notes, and billing information.

If someone other than yourself contacts our office, and are not listed below, we will not release any information.

Name: _____ Relationship: _____

Check all items of information that may be released to above person(s):

- Prescriptions/Refills Appointment Time Diagnosis/Chart Notes Billing Information

Name: _____ Relationship: _____

Check all items of information that may be released to above person(s):

- Prescriptions/Refills Appointment Time Diagnosis/Chart Notes Billing Information

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND OFFICE POLICIES:

I hereby acknowledge that I have been offered Emerald Psychiatry & TMS Center’s Notice of Privacy Practices and Office Policies.

_____ I have been offered a copy of the Notice of Privacy Practices.

INITIAL

_____ I have been offered a copy of the Office Policies.

INITIAL

Print Name

Signature

Date

Guardian Signature (if applicable)

Date

APPOINTMENT CANCELLATION NOTICE:

If it is necessary to cancel an appointment, please call our office at least 24 hours before your scheduled appointment date. If a 24-hour notice is not given, a cancellation fee will be applied to your account.