Evansville Psychiatric Associates
Complete Outpatient Mental Health Care

2015 Maxwell Avenue, Evansville, IN 47711
Phone: 812-422-7974 Fax: 1-812-671-0627
Email: faxes+2038119@waitingroomsolutions.com

EVANSVILLE PSYCHIATRIC ASSOCIATES REGISTRATION AND CONSENT

Patient Name: First: _____ Middle: _____ Last: _____

Preferred Name: _____ DOB: _____ Social Security # _____

Gender: ○Male ○Female ○Transgender Male ○Transgender Female ○Non-Binary/Genderfluid

Address: _____ City: _____ ZIP: _____

Home # _____ Cell # _____ Work # _____

Employer: _____ Emp Phone # _____

Patient's email address: _____

Preferred Local Pharmacy/Street address: (Choose one) _____

We ask to communicate with your Primary Care Provider to improve care/avoid drug interactions:

Doctor/NP/PA: _____ Phone: _____

Primary Insurance:
Subscriber Name: _____ Employer:_____
DOB: _____ SSN: _____ Email: _____
Address: _____ City: _____ Zip: _____
Insurance Company: _____ Ins Phone # _____
Subscriber ID # _____ Group # _____

Secondary Insurance:
Subscriber Name: _____ Employer:_____
DOB: _____ SSN: _____ Email: _____
Address: _____ City: _____ Zip: _____
Insurance Company: _____ Ins Phone # _____
Subscriber ID # _____ Group # _____

Emergency Contact(s): (If the patient is under 18, please complete this section with parent names)

Name: _____ Relationship: _____ Phone: _____
DOB: _____ SSN: _____ Email: _____
Address: _____ City: _____ Zip: _____

Name: _____ Relationship: _____ Phone: _____
DOB: _____ SSN: _____ Email: _____
Address: _____ City: _____ Zip: _____

CONSENT TO TREATMENT AND OFFICE POLICY REVIEW

EVANSVILLE PSYCHIATRIC ASSOCIATES, LLC is an independently owned clinic, providing outpatient mental health services through our professional staff of Board Certified Psychiatrists, Psychiatric Nurse Practitioners, Clinical Psychologists, and Professional Counselors, Licensed Clinical Social Workers, and Licensed Mental Health Counselors. All providers are Independent Contractors and each clinician is individually contracted with their specific insurance companies, EAP (Employee Assistance Programs), and treatment panels.

Important: Please initial where indicated.

_____**Check in/Arrive Early, PAYMENT EXPECTED AT TIME OF SERVICE:** Check in 15 minutes before scheduled in-office appointments, or 5 minutes before at-home telehealth appointments. Use the Patient Portal to verify your demographics, insurance, and pharmacy information. For in-office visits, please have your Driver's License/state ID and insurance card(s). Copays/deductibles are due at time of service *unless previously arranged with our billing department*. Payments may be made via the Patient Portal or by phone. We accept cash, check, VISA, MASTERCARD, DISCOVER, and AMERICAN EXPRESS. Unpaid copays may incur an additional fee. Receipts are available through your Patient Portal.

_____**CREDIT CARD ON FILE:** In order to establish or continue care with us, and as a convenience, patients are asked to keep a credit card on file with our office. When you sign a credit card authorization, any unpaid balances and fees will be processed for you. Should you become delinquent on your account and/or be sent to collections, a new card must be placed on file before you can schedule further appointments. Paper statements are not mailed, regardless of account status. Statements are sent by email. If we do not have a current card on file, missed copay/coinsurance fees and statement fees will apply to all balances.

_____**BILLS:** Statements are exclusively emailed and may be paid online, by phone, by mail, or in office. Payment is required upon receipt of this statement. Charges that are unpaid after 90 days may be sent to collections without additional notice. Collection fees are set by state law and incur an additional 33% fee that is the patient's responsibility. Returned checks incur a non-sufficient fund (NSF) fee per Indiana allowance. If we are required to send a printed statement, an additional mailing fee will be added (see front desk for current fee).

_____**NON-COVERED SERVICES:** Services not covered by insurance are the patient's responsibility. This includes service charges if we are out of network, whether with your primary or secondary insurance. Other examples include letters, forms, mailings and certain *types* of appointments. We do not traditionally allow appointments with two different providers on the same day, as such situations may not be covered by insurance and could cause the full cost of the appointment(s) to fall on the patient. It is your responsibility to know how your insurance covers your services. Your insurance policy is a contract between you and your insurance company. Likewise, our relationship is with you as a patient and *not* the insurance company. Costs for non-covered requests vary depending on time and personnel involved. Estimated costs are posted at the front desk.

_____**Rx INSURANCE:** Your insurance may have assigned prescription benefits to another policy, separate from your standard medical coverage. If you have separate coverage for your prescription benefits, we will need this information. We may be required to complete prior authorizations for your prescriptions. If we have not been provided with this, we may be unable to complete those requests.

PATIENT PORTAL: Your Patient Portal is set up through the email address that you have provided to us and is accessed through our website. Your email address is your username, unless the patient is a minor; if the identified patient is a minor, the username for the child's account is your email with a "+childsname" modification inserted between the user name and the domain. For example: youremail+childsname@domain.com. Emails will come directly to your email address.

Your Patient Portal is HIPAA compliant and secure, and can be used to pay your bill, request refills, make/change/cancel appointments, and send messages to your provider. You can send a message 24/7 and we will respond on the next business day and/or when we hear back from your provider.

If you are having trouble with your password, contact the office to reset your password.
If you do not have online access and need to call, leave the nurses only *one* message. Leave all the information for your request, as our voicemail will not cut your message off. Additional messages will delay us in helping you.

NOTIFY US IMMEDIATELY OF INSURANCE CHANGES: Notify us immediately of insurance changes or Medicaid enrollment. New policies require a verification of benefits, and may need pre-authorization or a change of provider. We do not bill traditional Medicaid, and those fees could become your responsibility. If you add Medicaid as a secondary insurance, the nurses may be unable to complete medication prior authorizations for you if your prescriptions are billed through Medicaid.

COURTEOUS WAITING ROOM BEHAVIOR is expected. Do not bring additional children or extraneous family members or friends to your appointment. Guest Wi-Fi is available. Do not talk on your phone, play audio aloud, or use a camera in our waiting room. If you cannot agree to these requests or are otherwise disruptive, you will be asked to leave and refunds will not be issued.

FOLLOW-UP APPOINTMENTS: At the end of your appointment, your provider will discuss a time frame for your follow-up appointment. Schedule your follow-up at check-out. If your appointment is by telehealth, please send a portal message after your appointment to request your follow-up and tell us the dates and times that would work best for you. If you are a therapy client and need a specific weekday and/or time for your appointments, you may schedule up to four future appointments with your therapist—then, after each appointment, you may schedule an additional appointment on your provider's schedule. If you no-show/late cancel, all future appointments are subject to cancellation.

If you are seeing a provider who prescribes medications for you, you must schedule/attend all requested appointments. You must have a follow-up appointment scheduled in order for the nurses to be authorized to handle refills, prior authorizations, and any paperwork you need for FMLA, ESAs, life insurance forms, etc.

REFILLS: Check with your pharmacy *first* to make sure if you have refills or a prescription *on hold/ on file*. If you submit refill requests by entering prescription numbers, make sure you are using *your most current bottle*. If you still need a refill, send a message through the Patient Portal. Patient Portal requests are the preferred method for these refill requests. Make sure to request all Schedule II and III prescriptions 7 days in advance to give the prescriber adequate time to submit your prescription. This also allows your pharmacy time to stock your medication.

If your pharmacy has had issues having your medication in stock, check with them that they have enough to fill your prescription. Re-prescribing adds more time to complete your request.

Patients who are prescribed Schedule II + medications are subject to random pill counts or Urine Drug Screens as part of the requirements of the Controlled Substances Act. If you are selected, then you must comply with the pill count on the same business day or submit a urine sample to a lab within 24 hours. You must keep your contact information current and make your voicemail works.

CANCELLATIONS: Use the Patient Portal to notify us of cancellations. If you need to cancel an appointment, please give us 48 hours' notice. Appointments that are missed or canceled in less than 24 hours are subject to a missed appointment fee. Fees and late arrival windows are posted at the front desk and website. If you have 2 or more missed and/or late canceled appointments, you are subject to having your case closed without additional warning. Arriving late for an appointment may be considered a missed appointment. Telehealth appointments follow these same guidelines. If you are forced to miss an appointment or you arrive late due to a verified emergency, please write or speak to the office staff. Each provider has a specific policy in regards to missed appointments, rescheduling, and fees, and will require payment and review by management before rescheduling.

If there is an illness or a transportation problem, or you are in a quarantine situation, please notify us and we will do our best to arrange a telehealth appointment for you. If your provider has a mobility or quarantine issue, they may also request to complete your appointment by telehealth. Some insurances differ on coverage for telehealth services. You are responsible for knowing the parameters of your insurance policy. Patients will be held responsible for telehealth services if they are not covered under the insurance benefits.

Office closings due to inclement weather, electrical outage, or natural disaster will be posted to our website and Facebook page https://m.facebook.com/evansvillepsychiatric/, or on X (formerly Twitter) @EvvPsychiatric. If we are able to arrange telehealth visits on those days, you will be contacted through the Patient Portal. Keep your contact information current with the office so we can reach you for emergencies.

PRIVACY: Our office complies with all HIPAA privacy regulations. If you wish to have a copy of these regulations, it is located on our website. Your providers at Evansville Psychiatric Associates may communicate with each other for coordination of care. Your providers may use transcribing software that utilizes AI for the purpose of dictation. This software does not release any identifying info outside of the clinic. Your health information remains confidential to our office with only a few exceptions: (1) Your insurance company may request records for payment, to approve a medication, or as part of an audit (2) Court subpoenas (3) Child or elder abuse as mandated by state law.

Outside of these very specific situations, information and records are released only with your authorization. Authorizations may be signed for a single release, a specific time period, or for the duration of your active patient status in our clinic. If you wish to allow someone to be able to speak on your behalf, request appointments, or handle billing, make sure we have a completed release that includes their name, their contact information, and the timeframe for the release.

TELEHEALTH APPOINTMENTS: We use a HIPAA compliant platform for telehealth. We need your accurate email address and current cell number. Invitations for your visit are sent early on the day of your appointment. Please call us immediately if you do not see your email. Make sure to check all email folders and spam. Your telehealth room name changes with each appointment.

If you are using a laptop/desktop, open your email and scroll to the bottom of your message. The room link is in a grey box at the end of your email. The grey box is a hyperlink that will open your telehealth room. If you are using a smartphone or tablet, make sure you have the GOOGLE MEET APP downloaded on your device. If you join early, or if your provider is running behind, your request to join may time out. If this happens, simply request to join again.

You must have a good internet connection and private space for your telehealth appointment. When you open your link, your device may ask for permission to access your camera and microphone for the appointment. Do not take calls or open other programs on your device during this time, as you may miss when your provider connects. If you are having trouble connecting, our office may call you. If you live out of state, you may be required to come across state lines or to the office even for a telehealth appointment. *This is dependent on your state's laws*. If you are required to come to the office, we will provide a private space and tablet for your appointment.

RECORD REQUESTS: Records can be faxed to a new provider at no charge. Requests for printed records must be approved by your provider and will incur fees per state standards (labor fee plus print page fees by number of pages and additional fees for urgent requests for printing within 48 hours or less, and certification). Attorney, disability and life insurance requests may incur fees.

AFTER HOURS EMERGENCIES: If you have an emergency after hours, you may reach a provider through the answering service. Please follow the prompts on our phone tree, 812-422-7974. If it is a non-urgent request, please use the portal or leave a phone message at the office.

PARENTS AND PARENTAL SEPARATION: The person who brings the child in for treatment is responsible for payment of any copay or balance due at time of service. IF THERE IS A DIVORCE SITUATION, THE PARENT OR RESPONSIBLE ADULT WHO BRINGS THE CHILD TO THE APPOINTMENT IS THE PERSON RESPONSIBLE FOR THE CHARGES, unless a prior authorization has been signed with the billing department.

WE WILL NOT BECOME INVOLVED WITH THE PARTICULARS OF YOUR DIVORCE. We will provide a receipt so that the responsible party can be reimbursed. We will not bill third parties for payments of balance due.

We do require a copy of any court orders in instances where there is a custody issue, restraining order, or Power of Attorney that we need documented.

The appointment that your child has with their health care provider is the child's appointment and should be a safe space for them. We do not engage in releasing records to a parent seeking litigation involving their child's custody, etc. If records are subpoenaed by the court, we will follow procedure and fax them directly to the judge or officer of the court as ordered.

Per HHS.Gov:
"HIPAA also allows a healthcare provider to determine, based on professional judgment, that treating someone as a patient's personal representative for HIPAA purposes would endanger the patient, and to refuse to treat the person as a personal representative under those circumstances. This applies whether the patient is an adult or a minor child."

COURT APPEARANCES: We do not traditionally perform court-ordered services. If you wish to subpoena your clinician to be a witness for a court case, be advised: these requests will require prepayment in full for the clinician's time to include preparation, travel, and testimony and cancellation of a day or more of appointments. You may request your clinician's fees so you are fully informed. Each provider has a separate agreement for court fees. If your clinician is treating your child: be aware that court involvement with your child's therapist is not therapeutic for your child, and may influence the therapeutic relationship the child has with the provider.

TRUST: Good mental health care requires mutual trust. We expect patients to be honest with their providers. We also ask that administrative staff be treated with respect. Aggressive, abusive, discriminatory, or destructive behavior will not be tolerated.

If you have a complaint or suggestion for improvement, please allow us the opportunity to hear it first. We take pride in providing excellent service, and we would love to have your feedback. We appreciate the opportunity to address any issues when possible.

By signing this form you acknowledge that you have read and understand the above information, rights, and responsibilities.

By signing this form, I authorize my insurance company to make payment directly to Evansville Psychiatric Associates unless I choose to pay for all services in full at time of service. I understand that medical records may need to be released to my insurance company in order to substantiate claims.

Signature of Patient: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____
(Required if patient is under 18)

Relationship of Parent/Guardian to patient: _____

Provide a copy of any custody agreement, court judgments, or POA papers necessary.

Witness: _____ Date: _____
(Office use only)

Credit Card Authorization Information

As a convenience to you Evansville Psychiatric Associates will keep a credit card authorization on file to fulfill your financial requirements. This ensures timely posting for your financial responsibility due at the time of service. If you have insurance we will bill the amount to insurance first and charge the card when the patient responsibility is posted to your account. Receipts are in the portal and can be provided upon request.

○ MasterCard	○ Visa	○ American Express	○ Discover

Is this an HSA or FSA Card? **O** Yes **O** No *If your card is an HSA, it will be charged for insurance based costs only. If the charge can not be billed to insurance it can not be paid with an HSA and you should consider adding a back-up card.*

Card Number:	CVV:
Card Holder Name: _____ Address: _____Zip:_____ Signature:	Expiration Date:

By signing this agreement I understand the terms and conditions listed above. I also understand that any charges incurred for treatment and are not included with this date's payments will be due at the next billing cycle. A receipt will be sent through the portal upon my request.

Declined charges are subject to fees; Failed payment plans are subject to fees or collections processing. (See Registration paperwork)

This Credit Card Authorization can also be used for the following patient accounts:

_____ _____ _____

OR

O **Complete for Credit Card OPT-OUT Only:** I understand that all balances are due on date of service or upon receipt of statement. If I opt out of placing a card on file, I understand that I will accumulate missed copay fees and statement fees. I understand that my balance must be paid in full to reschedule. Balances are billed by email only and forward to collections after 3 billing cycles.

Signature: _____ Date:_____

Initial Assessment - Adult (17 and older)

Date: _____

Name: _____ Cell Phone: _____

Age: _____ Email: _____

What are your strengths, interests, and/or hobbies? _____

_____

_____

What are the concerns/issues that bring you to therapy today? _____

_____

_____

_____

When did these symptoms begin? _____

How frequently do these symptoms occur? _____

How much do these symptoms impact your daily routine/functioning? (1-no impact; 10-severe impact)

1 2 3 4 5 6 7 8 9 10

What strategies have you tried to address these concerns? _____

_____

_____

What changes are you hoping to see in therapy? _____

_____

How hopeful are you about seeing improvement in yourself?

1 - Not at all hopeful 2 - a little hopeful 3 - somewhat hopeful 4 - very hopeful

If you are not hopeful, why not? _____

_____

Marital Status: Single Separated Divorced Married Cohabiting

What is your spouse/partner's name? _____

How long have you been married/cohabiting? _____

How would you describe your current relationship? Good Fair Poor

Are you sexually active? Yes No

Are you pregnant? Yes No

Please list any children you have, including age and who they live with:

Please list everyone currently living in the home and their relationship to you: _____

_____

Please list any psychiatrists, psychologists or therapists you have seen in the past.

_____

_____

Have you had any psychiatric hospitalizations? Yes No

Please list your diagnoses, dates, and locations of treatment: _____

_____

Current Medications Prescribed	Dosage	Frequency	Improvement Noticed

Past Psychiatric History

Prior outpatient alcohol/substance abuse treatment?	Yes	No
History of non-suicidal injury (scratching, cutting, burning)?	Yes	No
Prior History of Aggression or Violence?	Yes	No
Legal charges stemming from aggression:	Yes	No
Incarceration stemming from aggression:	Yes	No

Legal Issues

Prior difficulties with the legal system ever?	Yes	No
Prior incarcerated?	Yes	No
Current legal issues?	Yes	No
COMMENTS/Explanation of positive Responses:		

Sleep and Current Functioning

Do you have trouble falling asleep?	Yes	No
Do you have any trouble staying asleep?	Yes	No
Usual bedtime: _____		
Usual wake time: _____		

Have you experienced any of the following recently:			**If yes, how long/when?**
Little interest or pleasure in doing things	Yes	No	
Feeling bad about yourself or that you are letting yourself or others	Yes	No	
Trouble concentrating or being easily distracted	Yes	No	
An increase or decrease in your energy level	Yes	No	
Poor appetite or overeating	Yes	No	
Recent weight gain/weight loss	Yes	No	
Feelings of hopelessness or helplessness	Yes	No	
Feeling anxious, worried or nervous	Yes	No	
Hearing voices or seeing things that are not really there	Yes	No	
Have you ever thought about suicide?	Yes	No	
Did you have a plan?	Yes	No	
Have you ever attempted suicide?	Yes	No	

Medical History

Who is your Primary Care Physician? _____

Date of last visit _____

Do you have other physicians? Yes No _____

Please circle all that apply: High/Low Blood Pressure Heart Disease Diabetes Gout Asthma Cancer

Emphysema Hay Fever/Sinusitis Bronchitis Hives Pleurisy Thyroid Problems Kidney Stones

Frequent Urinary Tract Infections/Bladder Infections Hepatitis Arthritis Ulcers Eczema HIV/AIDS

Dizziness/Fainting History of any STDs Bleeding Tendencies History of Head Injury Seizures

Loss of Counsciousness Other:_____

Do you have any known allergies? Yes No

If yes, please explain: _____

Do you currently smoke? Yes No

Do you drink alcohol? Yes No

How much, how often? _____

Have you ever felt you might have a problem with alcohol? Yes No

Has anyone ever told you that you had a problem with alcohol? Yes No

If yes, please explain: _____

_____

Please list any medical or mental health problems in your family (parents, siblings, grandparents, aunts/uncles):

_____

_____

_____

Were there any problems or complications with your birth? Yes No

Please list any medical hospitalizations (include date and reason for hospitalization):

_____

_____

_____

Please list any recent blood work or other testing you have undergone (indicate where/when):

_____

_____

Psychiatric Social History

Were you adopted?	Yes	No		
Relationship status of biological parents:	Married	Divorced	Separated	Never married
Loss of parent by death prior to age 18?	Yes	No		
Would you describe your childhood as	Happy	Average	Unhappy	
How would you describe your socio-economic status/class growing up?	Lower	Middle	Upper	
During childhood, did you experience any of the following:				
Emotional abuse	Yes	No		
Physical abuse	Yes	No		
Sexual abuse	Yes	No		
Have you ever witnessed violence or been involved in a violent episode?	Yes	No		
COMMENTS/Explanation of Positive Responses:				

Education & Work

Highest Grade Completed: _____

Did you experience difficulty in school? Yes No

Did you receive any Special Education Services? Yes No

If yes, please explain: _____

_____

Do you work?: Yes No

Where? _____

Job Title _____

How long have you been at this job? _____

How many jobs have you had in the last 5 years? _____

Are you satisfied with your current work? Yes No

What problems or stressors have you had at work? _____

_____

_____

Do you have current financial stressors? _____

_____

Are you currently on Disability?	Yes	No		
Are you currently seeking Disability?	Yes	No		
Are you now or have you ever been a member of the Armed Services?	Yes, active	Yes, inactive	Yes, retired	No

If so, which branch? _____

Please provide any current or past use of substances			If yes, how much how often?
Alcohol: (beer, wine, liquor)	Yes	No	
Cannabinoids: (marijuana, hashish)	Yes	No	
Opioids and Morphine Derivatives: (codeine, morphine, heroin, opium)	Yes	No	
Stimulants: (cocaine, amphetamines, methamphetamines)	Yes	No	
Club Drugs: (MDMA, GHB, Flunitrazepam)	Yes	No	
Dissociative Drugs: (Ketamine, PCP, Dextromethorphan, salvia)	Yes	No	
Depressants: (barbiturates, benzodiazepines)	Yes	No	
Hallucinogens: (LSD, Psilocybin, Mescaline)	Yes	No	
Anabolic steroids: (depo-testosterone, anadrol)	Yes	No	
Inhalants: (huffing, glue, solvents etc)	Yes	No	
Intravenous drug use	Yes	No	
Have you had any difficulties with any of the following issues related to substance abuse?	Yes	No	
TOLERANCE (increased amount of substance required to obtain initial effect of the drug)	Yes	No	
WITHDRAWAL (symptoms of physiologic or psychological distress upon stopping or reducing the amount of drug used)	Yes	No	
consumption exceeds intended amount	Yes	No	
efforts to reduce/control consumption	Yes	No	
excessive time spent related to substance use and leading to disruption of daily functioning	Yes	No	

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name: _____ Date of Birth: _____

Address:_____

Any Previous Name(s): _____ SSN: _____

The undersigned, Patient or Personal Representative of Patient, does hereby request and authorize Evansville Psychiatric Associates to:
(Please **CHECK** all that apply)

- ☐ Receive records from
- ☐ Schedule and cancel appointments with
- ☐ Release records to
- ☐ Manage billing matters with

The following office or individual:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ FAX:_____
(**NOTE**: This release is **VOID** unless this section is filled out with the relevant party's information)

For the following purpose: **O** Patient request, **O** Coordination of Care, **O** Legal Purpose, **O** Billing
(Please **CHECK** all that apply)

- Offices or individuals that do not share a physical address will each need a separate signed release.
- Medical records may include but are not limited to the following information: described and disclosed demographics, symptoms, history and physical, diagnosis, functional status, treatment plan, medication, psychological test results, psychiatric records, recent lab results, prognosis, attendance, progress, which may include mental health and drug/alcohol information.
- Information shared through this release may be subject to redisclosure.
- This release may be revoked early at any time, by providing a written request to Evansville Psychiatric Associates.
- Refusal to sign this release does not affect ability to obtain treatment, payment for services, or eligibility for benefits, with the exception of treatment dependent upon information from the above party.
- This release will expire 1 year after the signed date, unless specified otherwise below.

This authorization will expire in: **O** 1 year from last appointment, **O** 1 year, **O** other: _____
(Please **CHECK** an option)

Signature of Patient / Parent / Guardian: _____

Date: _____