Stephens Ladd Psychiatry

Dr. Jeff Stephens | Dr. Mary Ladd | Cara Reeves, PhD

New Patient Registration Form

Patient Information:

Full Name ______________________________ Preferred Name: ____________________

DOB: ____________ Gender: ________ Race: __________ Marital Status: _______________

Primary Ph # (for apt reminders):__________________ Secondary Ph #: __________________

Street Address: ____

City: ___________________________ State: ___________ Zip Code: _________________

Email Address: ____

Emergency Contact Information:

****If under the age of 18 list parents/guardians we are allowed to communicate with about care****

Name ____________________________________ Relationship: ___________________

Primary Phone Number: ( ) _______________ Secondary Number: ( ) _______________

Name ____________________________________ Relationship: ___________________

Primary Phone Number: ( ) _______________ Secondary Number: ( ) _______________

Guarantor Information: (this person is responsible for paying the balance after each visit, as you should already know we are fee for service and balance is due at the time of service)

Name ____________________________________ Relationship: ___________________

Primary Phone Number: ( ) _______________ Secondary Number: ( ) _______________

Pharmacy Information:

Local Pharmacy Name: ______________________ Phone Number: __________________

Street Address: ____

Please list all Drug Allergies: ____

Authorization:

I hereby give consent to treatment and/or medication. I hereby authorize/consent Stephens Psychiatry to the release of pertinent medical information concerning my present illness, including but not limited to Mental Health/ Substance Abuse. I understand that I remain personally responsible for payment. I hereby authorize/ consent to Stephens Psychiatry the release of medical information, including MH/SA, to other clinicians and medical personnel for continuation of care. I hereby authorize/consent that I understand the policies, procedures, and financial policy of Stephens Psychiatry and agree to abide by them. I have received a copy of Stephens Psychiatry Notice of Privacy Policy.

___________________________	___________________________	____________
Signature of Patient/Guardian	Patient Name (Print)	Date

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Authorization for Release of Medical Records

Patient Name: ______________________________ **DOB:** ___/___/___ **Age:** _____

Release Records to: (Where do you want the information sent? Who may have the information?)	Name of Individual/healthcare provider/hospital/practice: ______________________ Phone: ______________ Fax: ______________
Obtain Records From: (Who has the information you want released? Please list the specific doctor/therapist and practice)	Name of Individual/healthcare provider/hospital/practice: ______________________ Phone: ______________ Fax: ______________
Purpose of Release: (Why is it needed)	○ Continuing Care ○ Legal, Disability, Insurance purposes ○ School ○ Patients Request
Treatment Dates to be Released:	○ Treatment dates from __________ to __________ (be specific) ○ All treatment dates
Family/Friends/Caregivers: (please list all that we would have permission to speak with, including BOTH parents)	1. Name: ______________________ Relationship: __________ Phone: __________ 2. Name: ______________________ Relationship: __________ Phone: __________ 3. Name: ______________________ Relationship: __________ Phone: __________

I understand this authorization may be revoked at any time, either verbally or in writing except to the extent that action has been taken in reliance on it. This consent will last while I am being treated for opioid dependence by the physician specified, unless the physician specified above is otherwise notified by me.

I understand that the records to be released may contain information pertaining to the psychiatric treatment and/or treatment for alcohol and/or drug dependency. These records may also contain confidential information about communicable diseases including HIV (AIDS) or related illness. I understand that these records are protected by the Code of Federal Regulations Title 42 Part 2 (42CFR Part2) which prohibits the recipient of these records from making any further disclosures to third parties without the express written consent of the patient.

______________________ ______________________ __________
Signature of Patient/Guardian | Patient Name (Print) | Date

______________________ ______________________ __________
Signature of Witness | Witness Name (Print) | Date