APS
Alabama Psychiatric Services

PLEASE PRINT

PLEASE COMPLETE PATIENT INFORMATION FORM BY FILLING IN THE BLANK LINES. PLEASE DO NOT PUT "SAME AS ABOVE" ON THE FORM. ALSO, PLEASE BRING TO THE APPOINTMENT YOUR INSURANCE CARD, DRIVER'S LICENSE AND A LIST OF ALL OF YOUR MEDICATIONS. WE WOULD LIKE TO REMIND YOU OF OUR 24 HOUR CANCELLATION POLICY, WHICH REQUIRES A 24 HOUR NOTICE IF YOU CAN NOT MAKE THE APPOINTMENT. IF YOU DO NOT NOTIFY US YOU WILL BE CHARGED $50.00. TO CHANGE OR CANCEL AN APPOINTMENT, PLEASE CALL THE OFFICE. YOU MAY ALSO CALL AFTER HOURS TO CANCEL YOUR APPOINTMENT AS LONG AS IT IS "BEFORE" MIDNIGHT AND YOU WILL NOT BE CHARGED FOR THE LATE CANCELLATION.

ACCOUNT NUMBER	APPOINTMENT TIME	DR. TO BE SEEN

PATIENT INFORMATION

NAME (FIRST, MIDDLE, LAST)	SEX	MARITAL STATUS	DATE OF BIRTH	AGE	SOCIAL SECURITY NUMBER
	❑ MALE ❑ FEMALE	❑ S ❑ M ❑ W ❑ D ❑ SEP.	/ /		

STREET ADDRESS	CITY, STATE, ZIP	COUNTY

HOME PHONE	CELL PHONE	WORK PHONE	EMPLOYER
( )	( )	( )	

LEGAL GUARDIAN INFORMATION (IF PATIENT IS LESS THAN 18 YEARS OLD)

LEGAL GUARDIAN NAME (FIRST, MIDDLE, LAST)	RELATIONSHIP TO PATIENT

HOME PHONE	WORK PHONE	LIVING ARRANGEMENT
( )	( )	

RESPONSIBLE PARTY INFORMATION

RESPONSIBLE PARTY IS PATIENT	NAME (FIRST, MIDDLE, LAST)	RELATIONSHIP TO PATIENT
❑ YES ❑ NO		

STREET ADDRESS	CITY, STATE, ZIP	COUNTY

HOME PHONE	CELL PHONE	WORK PHONE	EMPLOYER
( )	( )	( )	

FINANCIAL AND POLICY HOLDER INFORMATION

PRIMARY INSURANCE

INSURANCE COMPANY	CONTRACT NUMBER	GROUP NUMBER

EFFECTIVE DATE	POLICY HOLDER NAME	POLICY HOLDER SOCIAL SECURITY NUMBER

POLICY HOLDER STREET ADDRESS	CITY, STATE, ZIP	POLICY HOLDER PHONE	DATE OF BIRTH	SEX
		( )	/ /	❑ MALE ❑ FEMALE

RELATIONSHIP TO PATIENT

SECONDARY INSURANCE (IF APPLICABLE)

INSURANCE COMPANY	CONTRACT NUMBER	GROUP NUMBER

EFFECTIVE DATE	POLICY HOLDER NAME	POLICY HOLDER SOCIAL SECURITY NUMBER

POLICY HOLDER STREET ADDRESS	CITY, STATE, ZIP	POLICY HOLDER PHONE	DATE OF BIRTH	SEX
		( )	/ /	❑ MALE ❑ FEMALE

RELATIONSHIP TO PATIENT

TERTIARY INSURANCE (IF APPLICABLE)

INSURANCE COMPANY	CONTRACT NUMBER	GROUP NUMBER

EFFECTIVE DATE	POLICY HOLDER NAME	POLICY HOLDER SOCIAL SECURITY NUMBER

POLICY HOLDER STREET ADDRESS	CITY, STATE, ZIP	POLICY HOLDER PHONE	DATE OF BIRTH	SEX
		( )	/ /	❑ MALE ❑ FEMALE

RELATIONSHIP TO PATIENT

AUTHORIZATION TO RELEASE INFORMATION:THE UNDERSIGNED AUTHORIZES ALABAMA PSYCHIATRIC SERVICES, P.C. AND ANY PHYSICIAN RENDERING SERVICE, TO RELEASE MEDICAL OR OTHER INFORMATION ABOUT THE PATIENT WHICH MAY BE NECESSARY FOR THE COMPLETION OF INSURANCE CLAIMS, REVIEW OF SERVICES, OR RECEIPT OF BENEFITS. SUCH INFORMATION MAY INCLUDE CURRENT MEDICAL RECORDS. THE INFORMATION MAY BE RELEASED TO THIRD-PARTY PAYORS, INCLUDING THE THIRD-PARTY PAYOR'S AGENT AND/OR REPRESENTATIVE OR ANYONE RESPONSIBLE FOR PAYMENT OF SERVICES.

AUTHORIZATION TO RELEASE INFORMATION TO REFERRING PHYSICIAN: I HEREBY AUTHORIZE ALABAMA PSYCHIATRIC SERVICES, P.C. TO RELEASE INFORMATION CONCERNING MY TREATMENT TO THE REFERRING PHYSICIAN.

ASSIGNMENT OF BENEFITS: THE UNDERSIGNED ASSIGNS TO AND AUTHORIZES DIRECT PAYMENT OF BENEFITS (INCLUDING INSURANCE BENEFITS, OTHERWISE PAYABLE WITH RESPECT TO THE PATIENT) TO ALABAMA PSYCHIATRIC SERVICES, P.C. THE UNDERSIGNED AGREES TO ASSIST IN PROCESSING CLAIMS FOR BENEFITS.

FINANCIAL RESPONSIBILITY: IN CONSIDERATION OF THE SERVICES PROVIDED OR TO BE PROVIDED, THE UNDERSIGNED AGREES TO PAY ALABAMA PSYCHIATRIC SERVICES, P.C. FOR THE SERVICES RENDERED OR TO BE RENDERED TO ABOVE-SAID PATIENT WITHIN 90 DAYS. IN FAILING TO DO SO, I HEREBY WAIVE ALL CLAIMS OR RIGHTS OF EXEMPTION AND AGREE TO PAY THE REASONABLE COST OF COLLECTION, INCLUDING A REASONABLE ATTORNEY'S FEE FOR THE COLLECTION OF THE ACCOUNT IF ASSIGNED TO AN ATTORNEY FOR COLLECTION.

I ACKNOWLEDGE THAT I HAVE READ THIS FORM AND UNDERSTAND ITS PURPOSE AND CONTENT.

GUARANTOR (AGREEMENT TO PAY) _____ DATE _____

PATIENT (OR AUTHORIZED REPRESENTATIVE/RELATIONSHIP TO PATIENT) _____ DATE _____

FOR OFFICE USE ONLY