Trinity Wellness Center

Registration Form

Today's Date: _____

PATIENT'S LAST NAME: _____ FIRST NAME: _____ MIDDLE INITIAL: _____

DATE OF BIRTH: _____ AGE: _____ SEX: M | F SOCIAL SECURITY NUMBER:_____-_____-_____

STUDENT STATUS (circle one): FULL-TIME | PART-TIME | NONE

EMAIL ADDRESS: _____

HOME PHONE: _____ CELL PHONE: _____

IS IT OKAY TO LEAVE A MESSAGE? PLEASE CHECK FOR YES OR LEAVE BLANK FOR NO: __ HOME | __ CELL

MAILING ADDRESS:

STREET: _____ P.O. BOX | APARTMENT:_____

CITY:_____ STATE:_____ ZIP CODE: _____

IT IS OKAY TO SEND MAIL TO THIS ADDRESS: ___ YES | ___ NO

OTHER FAMILY MEMBERS SEEN HERE: _____

OCCUPATION: _____ EMPLOYER: _____

PHARMACY NAME: _____ ADDRESS: _____ PHONE: _____

PRIMARY CARE PHSYCIAN: _____ PHONE: _____

INSURANCE PROVIDER: _____

EMERGENCY CONTACT:

NAME:_____ RELATIONSHIP: _____ PHONE: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Trinity Wellness Center or insurance company to release any information required to process my claims.

NAME: _____ DATE: _____

CONSENT FOR EXCHANGE OF INFORMATION

ANYONE NOT LISTED BELOW WILL NOT BE PROVIDED WITH ANY PATIENT INFORMATION.

I, _____ give permission for Trinity Wellness Center to (exchange, release, obtain) information with the following people (family members, spouse, or friends):

_____ - ___ BILLING, APPOINTMENTS, MEDICATIONS ONLY | ___ WHOLE CHART/RECORDS

_____ - ___ BILLING, APPOINTMENTS, MEDICATIONS ONLY | ___ WHOLE CHART/RECORDS

_____ - ___ BILLING, APPOINTMENTS, MEDICATIONS ONLY | ___ WHOLE CHART/RECORDS

Trinity Wellness Center

Registration Form

I authorize Trinity Wellness Center to exchange, obtain, or release information to my insurance provider for the purpose of billing.

I understand that this practice has multiple providers. I authorize all staff of Trinity Wellness Center to exchange, obtain, and release information for the purpose of coordinating my care at this facility.

This consent is valid for one year, unless otherwise stated: _____

This consent is fully understood and made voluntarily on my behalf. I understand that I may withdraw this consent at any time.

Signature: _____ Date: _____

TRINITY WELLNESS CENTER OFFICE POLICIES

PLEASE READ CAREFULLY AND SIGN

By signing you agree to the policies and take responsibility of being informed of the policies.

COPAY | DEDUCTIBLES

Fees associated with insurance are due prior to being seen by your provider. It is the patient's responsibility to be informed of their insurance policies.

If a patient arrives for that day's appointment and cannot produce their insurance information, the patient will be responsible for the **self pay** amount for that appointment and any future appointments until insurance information is provided to the office.

In the case that a patient carries a balance from previous appointments the patient must be in contact with the billing department making efforts to resolve the balance. The copay and a payment toward the balance will be expected at every visit until the balance is fully resolved. The office reserves the right to demand payment before any further services are rendered.

If your insurance changes you are advised to call prior to your appointment to verify that your provider accepts your new insurance.

WE DO NOT ACCEPT: Medicaid | Medicare

NO SHOW | LATE CANCELLATION FEES

Each provider has set their own individual missed appointment fee. The fee will be collected at the next appointment time or via the billing department. The fee will also apply to any appointment that you cancel within a 24 hour window of the scheduled appointment time.

We have a voicemail setup on the weekends to allow patients to cancel any Monday appointments. Emergencies will be handled on a case by case basis and at the provider's discretion. When leaving a voicemail please include: NAME, DATE OF BIRTH, PHONE NUMBER, & REASON FOR YOUR CALL.

Failure to receive a reminder email regardless of fault does not excuse a missed appointment nor does it waive the missed appointment fee.

If a patient is 10 minutes late or more to any appointment, the office reserves the right to ask the patient to reschedule the appointment & will be responsible for a missed appointment fee.

Trinity Wellness Center

Registration Form

MEDICATION REFILL

A refill fee of $20.00 will be charged upon the request for medication outside of a scheduled appointment time. It is the provider's duty to ensure that the patient has enough medicine to last until the next office visit. It is the patient's responsibility to schedule the follow-up appointment at the time of check out to secure the next appointment time that works best for them.

PAPERWORK PROCESSING FEE

Individual providers set their own paperwork fees. These fees are based on the complexity of the paperwork and the timeframe they are given. Providers may also require an appointment be scheduled to fully complete the paperwork. Providers have the right to decline paperwork requests that they are unable to complete. Processing time may vary.

REQUEST OF MEDICAL RECORDS

If a patient is requesting records for personal use there will be a medical record fee. If a patient is requesting records be sent to another office a signed records release must be completed by the patient. Medical records requests generally take about 5 -7 business days.

CONSENT FOR TREATMENT

I understand that I have chosen to receive psychiatric/psychological services from Trinity Wellness Center. This is includes Dr. R. Thomas Mathew, M.D. and his associates affiliated with the practice. I understand that my choice to seek services here was done voluntarily and I may terminate treatment at any time. Trinity Wellness Center reserves the right to terminate treatment at any time after giving a thirty day written notice to the last address on record.

I understand that my participation in the recommended treatment includes attending all scheduled appointments. I understand that any recommendations will be explained to me and it is then my responsibility to ask questions if I do not fully understand. I agree to hold Trinity Wellness Center and its associates harmless if I fail to understand or follow the recommended treatment plan. I have the right to accept or reject any treatment recommendations at any time. I understand that there is no assurance or guarantee that my medical or psychiatric illness will respond to treatment by any physician. I understand that Trinity Wellness Center is limited to outpatient services and I am responsible for securing an inpatient facility if the need for one should arise. I understand that in the event of an emergency, I am responsible for seeking emergency treatment at a local emergency room or in-patient psychiatric facility.

I understand that I have a responsibility to procure, maintain, and properly care for the storage and security of all medications prescribed. I understand that it is my responsibility to assure that the medication is not lost, stolen, or destroyed. I am also aware that it is illegal to exchange prescription medication with another person without a prescription.

By signing below, you indicate that you have read the practice information and consent to treatment/notice of our privacy practices and agree to abide by the terms. It also indicates your clear understanding as to you (your child's) responsibilities according to the office/financial policies and your agreement to abide by these policies, and your consent to receive treatment at Trinity Wellness Center as well as consent for providers in this facility to consult about your care with other providers who practice in this facility.

_____ _____

Patient/Parent/Guardian/Legal Representative Signature Date

Trinity Wellness Center

Registration Form

PLEASE READ BEFORE SIGNING
COPAY/CANCELLATION/NO SHOW POLICY

It is the policy of The Trinity Wellness Center providers to require a 24 hour notice for all cancellations. Any **same day cancellations** or **no shows** will incur a fee which is designated by your provider.

Please understand that providers here are independent contractors, not employees. Compensation for providers is earned at the time you *arrive for appointment*, *pay your copay*, and *your insurance company is billed* for the appointment. As your time is valuable to you, please respect the specific time that has been set aside for your appointment by your provider.

Late cancellation and no show fees may be waived at the discretion of your provider for extenuating circumstances with appropriate documentation (doctor's note, letter from boss, etc).

Documentation must be provided at the next appointment, prior to being seen.

You may use the Patient Portal to cancel your appointment or leave a message in our general mailbox.

Thank you for understanding.

_____ _____

SIGNATURE DATE