Psychiatric Services *of* Southern Illinois

2900 Frank Scott Parkway West - Ste 990 - Belleville, IL 62223
Phone (618) 236-6501 Fax (618) 236-6551

Dear New Patient:

Thank you for entrusting us with your care. I know your time is valuable so we are sending this packet in advance to help us prevent any inconvenience or unnecessary delays. Please ***read this packet carefully*** and complete the paperwork attached. Please **PRINT** ***IN BLACK PEN*** and bring it with you (filled out) to your first appointment.

Please arrive on time. ***If you are late for your appointment, you may need to be rescheduled for a later date***. Keep in mind that new patient appointments may be scheduled weeks in advance, so another new patient appointment *may not be available for several weeks.* We will call to remind you of your appointment, please confirm your appointment with our office or your appointment will be cancelled.

If, for some reason, you cannot attend your appointment*, please call the office with at least 24 hours notice so we can cancel your appointment and reschedule you.*

For your first appointment you will need your:

- **Paperwork**
- **Insurance card(s)**
- **Co-pay and/or referral your insurance requires**
- **A list of medications or supplements you are taking**
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Due to time constraints on your initial evaluation and the need for patients undivided attention, please make sure you have appropriate childcare or please reschedule your appointment.

Per insurance company regulations co-pay is due at the time of service.

Please note **we do not accept Illinois Public Aid (IPA)**. ***If you have this insurance as a primary or secondary insurance we cannot see you.***

Thank you,

PSSI

PATIENT INFORMATION

NAME (Last, First Middle):_____

PREFERRED NAME:_____ PRONOUNS: She/Hers ◯ He/His ◯ Other:_____

E-mail:_____

ADDRESS: _____ CITY: _____ STATE:_____

ZIP:_____ HOME PHONE: (_____)_____ WORK PHONE: (_____)_____

CELL: (_____) _____

SOCIAL SECURITY NUMBER: _____ DATE OF BIRTH:_____

STATUS: Married ◯ Single ◯ Divorced ◯ Widowed ◯ RACE:_____

PATIENT EMPLOYER: _____ OCCUPATION:_____

EMPLOYER ADDRESS: _____

CITY:_____ STATE:_____ ZIP:_____

PRIMARY CARE PHYSICIAN: _____ CITY/STATE:_____

PRIMARY INSURED – INFORMATION

(Please have insurance cards available for copying & verification)

CARDHOLDER NAME (Last, First Middle):_____

CARDHOLDER DATE DOB:_____ SOC SEC NUMBER:_____ SEX: M ◯ F ◯

HOME PHONE:_____ WORK PHONE:_____

CARDHOLDER ADDRESS:_____ CITY:_____

STATE:____ ZIP:_____

INSURANCE PLAN NAME:_____ ID #:_____

GROUP #:_____

CARDHOLDER EMPLOYER NAME:_____

CARDHOLDER EMPLOYER ADDRESS:_____ CITY:_____

STATE:_____ ZIP:_____

SECONDARY INSURANCE CARRIER - INFORMATION

PLAN NAME:_____ GROUP #:_____

ID #:_____

CARDHOLDER NAME (Last, First Middle):_____

CARDHOLDER DATE OF BIRTH:_____ SOC SEC NUMBER:_____

EMERGENCY DATA INFORMATION

NAME:_____ RELATIONSHIP:_____ PHONE #:_____

RELEASE OF PATIENT MEDICAL INFORMATION - AUTHORIZATION

I authorize Psychiatric Services of Southern Illinois, LLC to discuss my medical care with the following family members or other individuals as designated below, this release will expire 1 year from date signed:

Name:_____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Patient Signature _____ Date: _____

Psychiatric Services *of* Southern Illinois

OFFICE POLICIES

PATIENT INTIALS: _____ Payment is due at the time of service on all office visits unless prior arrangements have been made. If you are covered under an HMO/PPO plan, it is YOUR responsibility to obtain the proper referrals. You will be responsible for any charges that are not covered under the companies' guidelines or charges where proper referrals were not obtained.

PATIENT INITIALS: _____ POLICY FOR NON-PAYMENT FOR SERVICES: It is office policy that routine healthcare will not be provided when a patient has a history of non-payment for services. Non-payment is defined as an account on which a patient balance is outstanding and there has been no effort by either the patient or responsible party to make payment on the account.

PATIENT INITIALS: _____ The office may request updated copies of your insurance cards at any time. Please bring your insurance cards with you at each visit.

PATIENT INITIALS: _____ If you are unable to keep your scheduled appointment, please give 24 hours advance notice. If 24 hours notice is not given, or your appointment is missed you may be charged**. This amount must be paid prior to any future visits** and is not billable to your insurance company.

We accept Visa/MasterCard, personal check, money orders, and cash. Returned/cancelled checks will be assessed a $25 fee.

Please read and sign the consent form below. This is a standard consent form that will be kept in your records to submit claims on your behalf.

RELEASE AND ASSIGNMENT

I hereby authorize Psychiatric Services of Southern Illinois, LLC to release to my insurance companies or their representatives any information including the diagnosis and the records of any treatment or examination rendered to me.

I also authorize and request my insurance company to pay directly to Psychiatric Services of Southern Illinois, LLC the amount due in my pending claim for Basic Medical, Major Medical, and/or Surgical Treatment or Services by reason of such treatment or services rendered to me.

I also understand that I will be held responsible for any collection costs, lawyers' fees, and all legal fees should my account be sent to a collection agency or other institutions for collection. I have also read and understand the Policy for Non-Payment for Services.

Patient Signature _____ Date _____

Psychiatric Services *of* Southern Illinois

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

1. Psychiatric Services of Southern Illinois, LLC is permitted to make uses and disclosures of protected health information for treatment, payment and health care operations, as described in the following examples:
    a. For treatment – The collection and sharing of protected health information by and among health professionals involved in the treatment and care of our patient.
    b. For payment – The use of protected health information in billing the patient's insurance carrier or their business partners to include personal identification, medical symptoms, and treatments for which Psychiatric Services of Southern Illinois, LLC seeks payment for services or in response to queries from the insurer or their business partners in adjudicating the claim.
2. Psychiatric Services of Southern Illinois, LLC intends to engage in one or more of the following activities:
    a. Psychiatric Services of Southern Illinois, LLC may contact the Individual to provide appointment reminders.
    b. A group health plan, or a health insurance issuer or HMO with respect to a group health plan, may disclose protected health information to the sponsor of the plan.
3. Psychiatric Services of Southern Illinois, LLC reserves the right to change the terms of this Notice. The new Notice provisions will be effective for all protected health information that it maintains.
4. Psychiatric Services of Southern Illinois, LLC will provide Individuals or Patients with a revised Notice by mail if requested, otherwise a new notice may be obtained at the offices.

Psychiatric Services *of* Southern Illinois

Receipt of Notice of Privacy Practices Form

I, _____, hereby acknowledge receipt of the physician's
(Patient's Name)

Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

I understand that the physician has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available.

Signed: _____ Date: _____

If you are not the patient, please specify your relationship to the patient _____.

Psychiatric Services *of* Southern Illinois

PRACTICE GUIDELINES – Please read carefully and sign. ***This is important information regarding our practice guidelines that applies to all of our patients*****. If you would like a copy to keep, ask the receptionist to make you a copy when you come in for your first appointment.**

Jeffrey S. Chalfant, D.O. is a board certified Adult Psychiatrist. Services in the office are rendered on an outpatient basis for psychiatric conditions only, and are offered for adult patients 18 years of age or older. Emergency conditions are referred to area emergency rooms.

Hours of Operation / Emergencies: We see patients by appointment only. Office hours are: Monday through Thursday 8 a.m. to 6 p.m. and Friday 8 a.m. to 2:00 p.m. Phone hours are: Monday through Thursday 9 a.m. to 5 p.m. and Friday 8 a.m. to 1:30 p.m. The office is closed from 12:00 pm - 1:00 pm for lunch. When someone is not available to answer your call, a brief message can be left on the answering machine, ***although we prefer that you call back during business hours*****.**

If you have an emergency or immediate life & death situation, **call 911**, *go promptly to an Emergency Room or Urgent Care facility for assistance*, or use the **CALL FOR HELP HOTLINE at 618-397-0963**. ***We do not provide emergency care or on-call services after hours or on holidays.***

Appointments: Appointments can be scheduled by the office staff. At the doctors' discretion, it is our policy to charge a $75 fee for Psychiatrist last minute cancellations and no-shows and $50.00 fee for all counselors, which will be billed directly to you. ***If you cannot or do not plan to keep your appointment, please let us know at least 24 working hours in advance to avoid a no-show charge.*** Insurance carriers will not pay for no-show charges.

If you have not had an appointment in a year's time, your case will be considered inactive and closed in this office.

Prescription Refills & Pharmacies: Please ***call your pharmacy at least two working days BEFORE you run out,*** and ask them to contact our office during business hours to approve a refill. Keep in mind if a prior authorization is needed it may take several days for a prior authorization to be obtained from your insurance company for prescriptions.

Refills of controlled medications (Ritalin, Concerta, Adderall, etc.): We are not responsible for any lost or stolen prescriptions. New prescriptions will not be reissued without a police report, and then it is at the discretion of the individual provider to reissue the prescription. If you fail to take medication as prescribed by increasing, decreasing, or stopping you will need to inform your provider. No refills will be given early.

Due to patient volume and shortened office hours, we discourage refill and prescription requests after 12:00 pm on Fridays and the day before a holiday.

Additional Charges: Due to the additional time and costs incurred, there will be a charge for forms completion (such as Disability or FMLA).

Payment for Service / Insurance: ***Payment is due at the time of service***. We accept your personal check, cash, or Master Card/Visa. ***Insurance co-pays, which are required by your insurance company, are due at time of service.*** You must bring your co-pays and insurance cards to each visit. If you have an insurance change, it is very helpful to advise us of this ***before*** attending your next appointment, as there are several insurances that require authorization to see our doctors. Please call with your insurance card available.

My signature below is my acknowledgement that I have read and understand the Policies, Guidelines, and statements above.

Patient Signature _____ Date _____

Printed Name _____