AUSTIN PSYCHIATRIC CONSULTANTS

Psychological Assessment, Individual, Group, Couples, Family, & Play Therapy

Irwin Schussler, DO, FACN *(Medical Director)* — Doreen Landrum, PhD *(Director)*

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A division of Psychiatric Consultants of Ft. Worth, PA
Serving the mental health needs of Texans since 1979

PATIENT INFORMATION SHEET

We are required to obtain some of the following information due to the Health Insurance Portability and Accountability Act (HIPPA) of 1996. For more information on this act and how you and your Protected Health Information (PHI) are affected, see our NOTICE OF PRIVACY PRACTICES *Form.*

____

Last Name **First Name** **Middle Initial**

____ **May we mail correspondence to this address? Y N**

Street Address **City** **State** **ZIP**

Home Phone: (______)____________ ✓ - can leave message ☐ **Work Phone: (_____)____________** ✓ - can leave message ☐

Alt. Phone: (_____) ____________ ✓ - can leave message ☐ **Date of Birth: __________ SS#: _____ - _____ - _______**

Relationship Status: __________ Spouse's/Sign. Other's Name: ____________ # of Children: ________

Emergency Contact: ______________ Relationship:____________ Phone: ______________

With whom may we <u>NOT</u> discuss/release information about your care? ________________________

<u>If you *would* like us to discuss your care with any individual, you must fill out a Release of Information</u>

ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION/COPAYMENTS

I hereby authorize APC to release any information deemed necessary by my insurance carrier for the processing of my insurance claim and/or certification of care provided. I authorize APC to receive payment directly on any medical benefits otherwise payable to me for services as described on the attached claim form not to exceed the reasonable and customary charge for those services. I am aware that any copayment or deductible due by me is to be made at the time of the visit. **If I am not the insured/responsible party, I authorize APC to exchange information with the insured/responsible party for billing purposes only.**

____________________ ______ ____________________ ______

PATIENT/GUARDIAN SIGNATURE **DATE** **PATIENT/GUARDIAN SIGNATURE** **DATE**

CUSTODIAL PARENT/CONSENT TO TREAT MINOR CHILD

I attest that I, ____________________, am the legal guardian, custodial parent, or managing conservator of minor child, ____________________, and have the right to make treatment decisions regarding him or her. Unless otherwise indicated, I agree to have an authorized **adult** present in the office (waiting room) during all sessions my minor child is attending. **If otherwise requested/discussed**, I give authorization that my minor child, ________________________, may be treated without my presence for therapy and/or testing procedures as discussed by my child's therapist.

I agree to inform the office in writing prior to my child's appointment if s/he is to be accompanied by or picked up by an individual other than custodial parent.

____________________ ______ ____________________ ______

PATIENT/GUARDIAN SIGNATURE **DATE** **PATIENT/GUARDIAN SIGNATURE** **DATE**