Lisa Lippincott, PMHNP-BC CBT

Patient Registration

Patient Name ____Age____ Date of Birth_________

Male____ Female ____ Social Security Number _______________________________________

Address____

City ____________________________ State ____________ Zip Code _______________________

Home phone___________________________ Cell phone_________________________________

Email Address ____

Employer ____

Employer Address ____

Work Phone __________________________

Status (Circle One): Single Married Separated Divorced Widowed

Emergency Contact, Relationship, Phone: ____

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Insurance Company____

Insurance ID # _________________________________ Group ___________________________

Insured Name ____

Insured Birth Date _______________________

Insured Employer __________________________ Relationship to Insured____________

Primary Health Provider (MD/Nurse Practitioner) ______________________________________

Phone Number (if known) ____

Pharmacy and Address ____

Patient's Name ____________________________________DOB:_________________________________

I, the undersigned, agree to the following by writing INITIALS on blank lines:

Consent for Medical Treatment

______I hereby voluntarily consent for care encompassing diagnostic procedures and treatment by my nurse practitioner or designee, as may be necessary in the judgment of the nurse practitioner. I also understand that I will be billed direct for those services provided. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made as to the results evaluations or treatments in this clinic. I understand that my medical record may be maintained on a computer-based system (EHR) and is available to persons involved in my care.

Release from Responsibility

______If I should leave the clinic against medical advice or prior to treatment being completed, I hereby relieve Lisa Lippincott and the clinic of all liability for my actions.

Authorization for Release of Medical Information

______I authorize the clinic's designee to release to the payors/insurers herein specified, MD Revenue Management, or to any other insurer or agency concerned with payment of my charges, any and all medication information related to clinic services which are deemed by the payors/insurers or other agencies to be required in the processing of applications for financial coverage for services rendered. I authorize release of my medical records to health care organizations consulted by the nurse practitioner.

PF-3000 (b) Notice of Privacy Practices Acknowledgment

______We keep a record of the health care services we provide you. You may ask to see that record. You may also ask for a correction in that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels this clinic to do so. You may see your record or obtain more information about your record by contacting our clinic manager.

______Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed as well as how to access your information.

______I understand that this clinic may use phone or text as a form of communication. I have reviewed the policy and agree and understand that this clinic will not be responsible for information loss or delay because of technical problems.

______ I DO NOT want phone or text communication from this clinic.
By my signature below, I acknowledge receipt of the Notice of Privacy Practices.

Patient Signature ____

Date /Time ________________________________

This form will be retained in your medical record.

Consent to Discuss Treatment

Patient Name ____

Date of Birth _____________________________

Check one:

__________I authorize to discuss my treatment with the following individuals listed below.

__________I DO NOT authorize discussion of my treatment with any individuals.

Name____

Relationship ____

Name____

Relationship ____

Patient Signature ____

Date ____________________________

TREATMENT AGREEMENT

Please read the following policies that constitute the treatment agreement between you, and Lisa Lippincott, PMHNP-BC CBT. Your ***initial and signature*** indicates that you have read and agree to these policies. If you have any questions, please speak with a member of our staff before signing this form.

Office Hours:

Our office hours are Monday through Thursday 9:00 am to 5:00 pm by appointment.
An automated voicemail system is available 24 hours a day, 7 days a week at (662) 205-6905. Messages left on our voicemail system will be returned within one business day, except for weekends and holidays. If we have not returned your call after 24 hours, please call again so we are sure that we have received your message.
In the event of an emergency, please call 911 or your local emergency services provider.

________ (Initial) Appointments: We see patients on an appointment-only basis, Monday through Thursday. Please call our office during business hours to schedule an appointment. A staff member will make reminder calls the day before scheduled appointments. These calls are a courtesy and we are not responsible for appointments missed due to incorrect contact information or non-receipt of a voicemail message. It is your responsibility to keep your scheduled appointments and to keep your contact information current. If your contact information has changed, please let a member of our staff know.

________ (Initial) Cancellations and No-Shows: We require a 24-hour notice to cancel or reschedule an appointment. Missed appointments and same-day cancellations will be charged an administrative fee of $75.00. This fee is **NOT** covered by insurance and must be paid before your next appointment is scheduled. We will attempt to collect this fee twice before sending your account to collections. If our office cancels your appointment due to unforeseen circumstances, you will not be charged a missed appointment. Emergencies will be reviewed on a case-by-case basis.

________ (Initial) Telephone Consults: In some cases, Lisa Lippincott may be able to discuss your care with you over the phone in lieu of an office visit. Phone consults are not covered by insurance and are handled on a case by case basis.

_________(Initial) Collections: Any account with an unpaid balance 60 days or older will be turned over to our collection's agency.

________ (Initial) Forms and Letters: Completion of narrative reports, medical leave forms, or other forms or letters are subject to fees based on the complexity of the form and the amount of time required to complete it ranging from $15.00 to $100.00 or more. These fees will be determined at the time the form is delivered to the office.

_________(Initial) Prescription Refills: All prescription refills must be handled during scheduled office appointments. Sufficient medication is prescribed to last until your next visit. It is your responsibility to inform Lisa Lippincott about what medications you need during your visit. Please pay attention to your medications and schedule appointments accordingly.

________ (Initial)Please allow 48 hours for medication requests.

Please bring the following:

Insurance card

Any recent lab results, medical reports (if available)

All medications that you are currently taking (must have a pharmacy label)

Discharge summaries, medical reports, diagnoses (if available)

If you have any questions about these forms or our office, please call our staff at (662) 205-6905

Thank you and we look forward to seeing you.

Lisa Lippincott, PMHNP-BC CBT

Bailey Young, Office Manager