**Instructions:**

1. **Fill out all attached pages (even Medicare form even if you are not on Medicare)**
2. **Email filled pages along with the front and back of your insurance card**

Date:_____

Patient Name: _____

Social Security #: _____

Date of Birth: _____ Age: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Mobile #: _____ Home #: _____ Work #: _____

Email Address: _____

Who referred you (how did you hear about us)? _____

Family Doctor (Primary Doctor): _____ Phone #: _____

Emergency Contact:_____ Phone #: _____

Primary Insurance: _____ ID #: _____

Insured's Name _____ Date of Birth: _____

**Informed Consent for Treatment**

I, (your name) _____ , agree and consent to participation in the health care services offered and provided by Riverview Psychiatric Medicine, PC, a health care facility. I understand that I am consenting and agreeing only to those services that the above provider is qualified to provide within (1) the scope of the license, certification, and training of the health care providers directly supervising the services received by the patient. If the patient is under the age of eighteen {18) or unable to consent to treatment, I attest that I have legal custody of this individual and am legally authorized to initiate and consent to treatment on behalf of this individual.

I have read and understand the statement: _____

**Payment Policy**

You are responsible for all co-payments and/or fees at the time of service, otherwise billing fees will be Incurred. If another party is responsible for your payments, please let us know prior to your visit so that we may make the necessary arrangements.

A fee of $45.00 will be charged for any return checks, along with a processing fee.

I have read and understand the statement: _____

**Cancellation Policy**

Any cancellations and/or rescheduling of appointments must be done at least 48 hours in advance of your appointment. **Patients who cancel the day of an appointment or do not show for their appointment will be responsible for the full self-pay rate (not just the co-pay rate).** Monday appointments must be canceled by noon of the preceding Friday.

**Appointment reminders/ confirmation calls are done as a courtesy**

I have read and understand the statement: _____

**Insurance Payment Order (Except Patients of Dr. Pardell or self-pay patients):**

I, (your name) _____ _, hereby authorize my insurance company to pay directly to Riverview Psychiatric Medicine, PC all benefits due to me. This policy was in full force an effective at time of treatment. I understand that I am financially responsible for all balances remaining after payment of possible insurance benefits, and that, should it become necessary, any and all reasonable collections and attorney fees will be added to my bill. I also understand that my health information and records will be used, as needed, to obtain payment for my health care services from my insurance providers. This may include certain activities the Riverview Psychiatric Medicine, PC staff may need to undertake before my health care insurer approves or pays for health care services recommended for me, such as determining eligibility of coverage for benefits, reviewing services provided to me for medical necessity, and undertaking utilization review activities.

I have read and understand the statement: _____

**Authorization:**

I, (your name) _____ _, hereby authorize Riverview Psychiatric Medicine, PC as needed and/or requested:

☐ To release any applicable mental health information to my primary care physician (PCP)
☐ To release any applicable substance abuse information to my PCP
☐ Not to release any Information to my PCP.

I may revoke this authorization at any time except to the extent that action has been taken in reliance upon it.

I have read and understand the statement: _____

**Forms:**

If you require legal, financial, or insurance forms to be completed by a Riverview Psychiatric Medicine, PC clinician, it will need to be done in a scheduled session otherwise you will be charged and billed for the time that clinicians take to fill out the requested documents.

I have read and understand the statement: _____

# Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

| **Credit Card Information** |
|---|
| Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX<br>☐ Other _____ |
| Patient Name_____ Name on Card: _____ |
| Card Number: _____ |
| Expiration Date (mm/yy): _____ CVV_____ |
| Cardholder ZIP Code (from credit card billing address): _____ |

I hereby authorize Riverview Psychiatric Medicine, P.C. to keep my signature on file and charge the provided credit card on the day of my scheduled appointment for services rendered.

_____ _____

Signature Date

National Government Services
A CMS Contracted Agent

**Medicare**

# Medicare Private Contract

This agreement is entered into this ____ day of _____, by and between _____ (hereinafter called "physician"), whose principal medical office is located at 370 Violet Ave Poughkeepsie NY 12601 and _____ (a patient enrolled in Medicare Part B, hereinafter called "patient"), who resides at _____.

## Background

A provision in the Social Security Act permits Medicare beneficiaries and physicians to contract privately outside of the Medicare program. Under the law as it existed prior to January 1, 1998, a physician was not permitted to charge a patient more than a certain percentage in excess of the Medicare fee schedule amount. A new provision, which became effective on January 1, 1998, permits physicians and patients to enter into private arrangements through a written contract under which the patient may agree to pay the physician more than that which would be paid under the Medicare program.

A "private contract" is a contract between a Medicare beneficiary and a physician or other practitioner who has opted out of Medicare for two years for all covered items and services he/she furnishes to Medicare beneficiaries. In a private contract, the Medicare beneficiary agrees to give up Medicare payment for services furnished by the physician/practitioner and to pay the physician/practitioner without regard to any limits that would otherwise apply to what the physician/practitioner could charge.

The purpose of this contract is to permit the patient (who is otherwise a Medicare beneficiary) and the physician to take advantage of this new provision in the Medicare law and sets forth the rights and obligations of each. This agreement is limited to the financial arrangement between Physician and Patient and is not intended to obligate either party to a specific course or duration of treatment.

Patients and physicians who take advantage of this provision are not permitted to submit claims or to expect payment for those services from Medicare.

*Exception:*

In an emergency or urgent care situation, a physician/practitioner who opts out may treat a Medicare beneficiary with whom he/she does not have a private contract and bill for such treatment. In such a situation, the physician/practitioner may not charge the beneficiary more than what a nonparticipating physician/practitioner would be permitted to charge and must submit a claim to Medicare on the beneficiary's behalf. Payment will be made for Medicare covered items or services furnished in emergency or urgent situations when the beneficiary has not signed a private contract with that physician/practitioner.

**A. Obligations of Physician**

1. Physician agrees to provide such treatment as may be mutually agreed upon by the parties and at mutually agreed upon fees.

2. Physician agrees not to submit any claims under the Medicare program for any items or services even if such items or services are otherwise covered by Medicare.

3. Physician acknowledges that (s)he will not execute this contract at a time when the patient is facing an emergency or urgent health care situation.

**B. Obligations of Patient**

1. Patient or his/her legal authorized representative agrees not to submit a claim (or to request that the physician submit a claim) under the Medicare program for such items or services as physician may provide, even if such items or services are otherwise covered under the Medicare program.

2. Patient or his/her legal authorized representative agrees to be responsible, whether through insurance or otherwise, for payment of such items or services and understands that no reimbursement will be provided under the Medicare program for such items or services.

3. Patient or his/her legal authorized representative acknowledges that that Medicare limits do not apply to what the physician/practitioner may charge for items or services furnished by the physician/practitioner.

4. Patient acknowledges that Medigap plans do **not**, and other supplemental insurance plans may elect not to, make payments for items and services not paid for by Medicare.

5. Patient acknowledges that (s)he has the right to obtain Medicare-covered items and services from physicians and practitioners who have not opted out of Medicare, and that the (s)he is not compelled to enter into private contracts that apply to other Medicare covered services furnished by other physicians or practitioners who have not opted out.

6. Patient acknowledges that (s)he or his/her legal representative understands that Medicare payment will not be made for any items or services furnished by the physician/practitioner that would have otherwise been covered by Medicare if there were no private contract and a proper Medicare claim had been submitted.

**C. Physician's Status**

Patient further acknowledges his/her understanding that physician (has/ has not) been excluded from participation under the Medicare program under Section 1128.

**D. Term and Termination**

This agreement shall commence on the above date and shall continue in effect until _____ (physician should insert date which is two [2] years after [s]he signs the affidavit). Despite the term of the agreement, either party may choose to terminate treatment with reasonable notice to the other party. Notwithstanding this right to terminate treatment, both physician and patient agree that the obligation not to pursue Medicare reimbursement, for items and services provided under this contract, shall survive this contract.

I have read and understand the provisions regarding private contracting.

By signing this contract, I accept full responsibility for payment of the physician's or practitioner's charges for all services furnished to me from the date written above.

| | |
|---|---|
| _____ | _____ |
| **Name of Physician (printed)** | **Name of Patient (printed)** |
| _____ | _____ |
| **Signature of Physician** | **Signature of Patient** |
| _____ | _____ |
| **Date** | |