



**Psychiatric Medical Associates, P.A.**  
**6404 International Pkwy, # 1010, Plano, TX 75093**  
**Phone # 972-267-1988**  
**Fax # 972-267-3434**

**Parent/Guardian Form**

Date: \_\_\_\_\_  
 Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Social Security # \_\_\_\_\_ Gender Identity: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home phone #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Work #: \_\_\_\_\_

***In Case of an Emergency, who can we contact?***

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_  
 Relationship: \_\_\_\_\_ Cell #: \_\_\_\_\_

***Can we release ALL personal health information to the following? (Please provide names)***

- School Nurse / School Counselors: \_\_\_\_\_  PCP: \_\_\_\_\_
- Employer / HR Department: \_\_\_\_\_  Counselor / Therapist: \_\_\_\_\_
- Social Security Department \_\_\_\_\_  Doctor: \_\_\_\_\_
- Texas Dept. of Family and Protective Services-CPS  Other:  \_\_\_\_\_

Attorney Office: If yes, please provide Attorney's name & phone #: \_\_\_\_\_

***Insurance Information:***

Insurance company: \_\_\_\_\_ Member ID/ Policy # \_\_\_\_\_  
 Group # \_\_\_\_\_ Insurance phone # \_\_\_\_\_ Employer: \_\_\_\_\_  
 Name of Primary Policy Holder: \_\_\_\_\_ Primary Holder's DOB: \_\_\_\_\_  
 Primary Holder's SSN: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

**Is Primary Policy Holder the Responsible Party?**  Yes  No (Adult patients are responsible for their own financials)

If No, Responsible Party / Guarantor's Information:

Responsible Party Name: \_\_\_\_\_ Home/Cell Phone # \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Patient/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



**ASSIGNMENT FOR BENEFITS**

I, \_\_\_\_\_ authorize Psychiatric Medical Associates, P.A. to bill my insurance company for charges incurred during the course of my treatment and to provide any information necessary to process my claims and to collect payment. I authorize my insurance company to honor a photocopy of this authorization and to assign my insurance benefits for these charges to Psychiatric Medical Associates, P.A.

**Sign:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Printed Name: \_\_\_\_\_

**INFORMED CONSENT**

**Child / Adolescent Patients and/or Patients with Legal Guardians**

If you are signing this Informed Consent as it relates to seeking services for a minor child/adolescent, please answer the following questions (providing names and relationship of each with the adolescent):

With whom (both parents, one parent, other) does the child/adolescent reside? \_\_\_\_\_

Who has legal custody of the child/adolescent? \_\_\_\_\_

I (We) \_\_\_\_\_, parent(s) / legal guardian of \_\_\_\_\_ accept the conditions for receiving services from

PMA's providers. I (We) have received a copy of Psychiatric Medical Associates, P.A.'s Notice of Privacy Practice and policy and procedures.

**Sign:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Printed Name: \_\_\_\_\_



Adolescent's Name: \_\_\_\_\_

Gender Identity: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

- Single
- Married
- Divorced
- Widowed
- Separated
- Never Married

Relationship to the patient:

- Parent
- Step-parent
- Legal Guardian
- Foster
- Personal Representative
- Adoptive Parent

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home phone # \_\_\_\_\_ Cell # \_\_\_\_\_ Work # \_\_\_\_\_

Employer \_\_\_\_\_

Father's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

- Single
- Married
- Divorced
- Widowed
- Separated
- Never Married

Relationship to the patient:

- Parent
- Step-parent
- Legal Guardian
- Foster
- Personal Representative
- Adoptive Parent

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home phone # \_\_\_\_\_ Cell # \_\_\_\_\_ Work # \_\_\_\_\_

Employer \_\_\_\_\_

If Parents are divorced, who has custody of child? : \_\_\_\_\_

Can we release ALL personal health information to non-custodial parent? \_\_\_\_\_

Besides parent do you give permission for someone else to bring patient to the doctor's appointments? \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to pt.: \_\_\_\_\_

If CPS is involved, please identify CPS caseworker name and number: \_\_\_\_\_

Are there any custody issues that your provider needs to be aware of? (If so please *briefly* explain): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



## **Notice of Privacy Practices**

This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

### **Our commitment to your privacy**

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information:

### **Use and disclosure of your health information in certain special**

#### **circumstances**

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

### **Your rights regarding your health information**

1. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Psychiatric Medical Associates, P.A. at 972-267-1988.



- 4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Psychiatric Medical Associates, P.A. at 972-267-1988. You must provide us with a reason that supports your request for amendment.
  - 5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact our front desk receptionist.
  - 6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact 972-267-1988. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
  - 7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.
- If you have any questions regarding this notice or our health information privacy policies, please contact 972-267-1988.

I \_\_\_\_\_ authorize Psychiatric Medical Associates, P.A. to release all information regarding my treatment to the following individuals:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

I hereby acknowledge that I have been presented with a copy of Psychiatric Medical Associates, P.A.'s Notice of Privacy Practices.

\_\_\_\_\_  
 Signature

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Printed Name

# DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 11–17

Childs Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  Male  Female Date: \_\_\_\_\_

Relationship with the child: \_\_\_\_\_

**Instructions** (to the parent or guardian of child): The questions below ask about things that might have bothered your child. For each question, circle the number that best describes how much (or how often) your child has been bothered by each problem during the **past TWO (2) WEEKS**.

		None Not at all	Slight Rare, less than a day or two	Mild Several days	Moderate More than half the days	Severe Nearly every day	Highest Domain Score (clinician)					
		During the past <b>TWO (2) WEEKS</b> , how much (or how often) has your child...										
I.	1.	Complained of stomachaches, headaches, or other aches and pains?					0	1	2	3	4	
	2.	Said he/she was worried about his/her health or about getting sick?					0	1	2	3	4	
II.	3.	Had problems falling asleep, staying asleep, or waking up too early?					0	1	2	3	4	
III.	4.	Had problems paying attention when he/she was in class or doing his/her homework or reading a book or playing a game?					0	1	2	3	4	
IV.	5.	Had less fun doing things than he/she used to?					0	1	2	3	4	
	6.	Seemed sad or depressed for several hours?					0	1	2	3	4	
V. &	7.	Seemed more irritated or easily annoyed than usual?					0	1	2	3	4	
VI.	8.	Seemed angry or lost his/her temper?					0	1	2	3	4	
VII.	9.	Started lots more projects than usual or done more risky things than usual?					0	1	2	3	4	
	10.	Slept less than usual for him/her, but still had a lot of energy?					0	1	2	3	4	
VIII.	11.	Said he/she felt nervous, anxious, or scared?					0	1	2	3	4	
	12.	Not been able to stop worrying?					0	1	2	3	4	
	13.	Said he/she couldn't do things he/she wanted to or should have done, because they made him/her feel nervous?					0	1	2	3	4	
IX.	14.	Said that he/she heard voices -when there was no one there- speaking about him/her or telling him/her what to do or saying bad things to him/her?					0	1	2	3	4	
	15.	Said that he/she had a vision when he/she was completely awake- that is, saw something or someone that no one else could see?					0	1	2	3	4	
X.	16.	Said that he/she had thoughts that kept coming into his/her mind that he/she would do something bad or that something bad would happen to him/her or to someone else?					0	1	2	3	4	
	17.	Said that he/she felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?					0	1	2	3	4	
	18.	Seemed to worry a lot about things he/she touched being dirty or having germs or being poisoned?					0	1	2	3	4	
	19.	Said that he/she had to do things in a certain way, like counting or saying special things out loud, to keep something bad from happening?					0	1	2	3	4	
		In the past <b>TWO (2) WEEKS</b> , has your child...										
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?			<input type="checkbox"/> Yes <input type="checkbox"/> No							
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?			<input type="checkbox"/> Yes <input type="checkbox"/> No							
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like Ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?			<input type="checkbox"/> Yes <input type="checkbox"/> No							
	23.	Used any medicine without a doctor's prescription to get high or change the way you feel (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?			<input type="checkbox"/> Yes <input type="checkbox"/> No							
XII.	24.	In the past <b>TWO (2) WEEKS</b> , has he/she talked about wanting to kill himself/herself or about wanting to commit suicide?			<input type="checkbox"/> Yes <input type="checkbox"/> No							
	25.	Has he/she EVER tried to kill himself/herself?			<input type="checkbox"/> Yes <input type="checkbox"/> No							

**PSYCHOLOGICAL INTAKE INFORMATION -PARENT/GUARDIAN**

• In your own words, please describe what brings your child in for counseling at this time?

---



---



---



---

Please check all your child's behaviors and symptoms that you consider problematic:

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> Distractibility    | <input type="checkbox"/> Change in appetite     | <input type="checkbox"/> Visual hallucinations | <input type="checkbox"/> Manipulative                   |
| <input type="checkbox"/> Hyperactivity      | <input type="checkbox"/> Withdrawal from people | <input type="checkbox"/> Defiance              | <input type="checkbox"/> Few friends                    |
| <input type="checkbox"/> Impulsivity        | <input type="checkbox"/> Anxiety/worry          | <input type="checkbox"/> Aggression/fights     | <input type="checkbox"/> Eating Issues                  |
| <input type="checkbox"/> Boredom            | <input type="checkbox"/> Panic attacks          | <input type="checkbox"/> Homicidal thoughts    | <input type="checkbox"/> Poor Sleep                     |
| <input type="checkbox"/> Poor memory        | <input type="checkbox"/> Fear away from home    | <input type="checkbox"/> Frequent arguments    | <input type="checkbox"/> Nightmares                     |
| <input type="checkbox"/> Sadness/depression | <input type="checkbox"/> Social discomfort      | <input type="checkbox"/> Irritability/anger    | <input type="checkbox"/> Hopelessness                   |
| <input type="checkbox"/> Thoughts of death  | <input type="checkbox"/> Obsessiveness          | <input type="checkbox"/> School problems       | <input type="checkbox"/> Self-harm behaviors            |
| <input type="checkbox"/> Compulsive         | <input type="checkbox"/> Stealing               | <input type="checkbox"/> Peer/sibling conflict | <input type="checkbox"/> Fire setting                   |
| <input type="checkbox"/> Destroys property  | <input type="checkbox"/> Legal problems         | <input type="checkbox"/> Crying spells         | <input type="checkbox"/> Running away                   |
| <input type="checkbox"/> Sexual behavior    | <input type="checkbox"/> Racing Thoughts        | <input type="checkbox"/> Loneliness            | <input type="checkbox"/> Computer addiction Mood swings |
| <input type="checkbox"/> Low self-worth     | <input type="checkbox"/> Suspicion/paranoia     | <input type="checkbox"/> Curfew                | <input type="checkbox"/> Computer addiction             |
| <input type="checkbox"/> Alcohol/drug use   | <input type="checkbox"/> Lying                  | <input type="checkbox"/> Lack of motivation    |   |

Other: \_\_\_\_\_

• If your adolescent has been in treatment before (therapy, medication, hospitalization, diagnosis etc.), please let me know what, when, where, and if you found it helpful.

---



---



---



• Are you or the adolescent involved with outside agencies or service providers such as Child Protective Services, the juvenile court system, alternative school programs (etc.)?

---

---

---

• **Adolescent Medical History**

Is your adolescent taking any medications, prescriptions, or over the counter medications? Please list any major medical problems that your adolescent has had (chronic illness, surgeries, head trauma, etc.):

---

---

---

---

• **Adolescent’s Developmental History**

**Check all that apply that you believe your child has experienced:**

- Planned pregnancy
- Problems with the pregnancy or delivery
- Adolescent currently sexually active
- History or current sexual abuse
- History or current neglect
- Death of a family member
- Adopted
- Divorce or separation problems
- History or current physical abuse
- History or current emotional/mental abuse
- Witnessed domestic violence or drug abuse
- Ethnicity/diversity/racial discrimination
- Unplanned pregnancy
- Bullying
- Suicide

[ ] Other traumatic experiences: \_\_\_\_\_

Developmental milestones delayed or not met (please describe): \_\_\_\_\_

---

---

---

Any history of Autism?  Yes  No

---





• **Family/Social History**

Who currently would you consider the adolescent's immediate family (names and ages please):

---

---

---

---

Please describe those relationships (close, distant, conflict, etc.): \_\_\_\_\_

---

---

---

Describe your adolescent's relationships with their friends: \_\_\_\_\_

---

---

---

• **School History**

School Name: \_\_\_\_\_

Current Grade Level: \_\_\_\_\_

Previous grade/retentions: \_\_\_\_\_

Special Classes: \_\_\_\_\_

Current GPA: \_\_\_\_\_

Behavioral problems at school (poor attendance, suspensions, violence, oppositional etc.):

---

---

---

---



Describe their relationship with their teachers: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Describe any learning problems: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Your confidentiality and the confidentiality of your adolescent are of utmost concern. However, please be aware that, as a psychologist, I am required by the State of Texas to report any suspicion of abuse towards a child or elderly adult. If you have any questions about limits to confidentiality, please speak with me directly.**

I have read, understood, and agreed to the policy listed above for Psychiatric Medical Associates.

**Signature** \_\_\_\_\_

Date \_\_\_\_\_

Printed Name \_\_\_\_\_



## General Office Policies and Procedures & Financial Agreements

Thank you for choosing Psychiatric Medical Associates, P.A. to be of service to you and your family for your behavioral healthcare needs. Please read these policies completely, and if you have any questions, do not hesitate to ask for clarification.

**Appointments:** Appointments are scheduled according to each patient's needs and the availability of the provider. The time of your appointment is reserved for you. You are expected to give 24 hours' notice with a staff member or with the answering service if you will not be keeping your appointment, **or it will be necessary for you to pay an unkept appointment fee of \$100.** Your insurance company will not cover this fee. It is your responsibility. Repeated "no show" or "late cancelled" appointments could result in you being referred out of the clinic to another practitioner. We do not do phone appointments. In case of an emergency, where you cannot come to your regular scheduled appointment and you have to do a phone appointment, you will be charged \$175 for the appointment. We cannot bill your insurance for the phone appointments, it is your responsibility.

**Maintaining Patient Status:** In our area of healthcare, it is very important that you be seen on a regular basis. At the end of each appointment, the doctor / nurse will tell you how long a period of time they would like you to schedule a follow-up appointment in the office. We urge you to make the follow-up appointment before you leave our office in order to schedule the most convenient time for you. **If you fail to keep and/or maintain follow-up appointments for a period of 120 days or greater, we will conclude that you have terminated the patient-physician relationship.**

**Phone Calls:** Emergency calls are handled as a priority. If you are experiencing a medical emergency, please call 911 immediately. Routine calls will be handled by our office staff during our normal business hours. Please leave a message on our voice mail or with our after-hour's answering service for the office staff. Your call will be returned on the next business day. Calls that require the doctor to call you back will be handled as timely as possible. Please leave your name, number and detailed message with our 24 hours answering service if your call is urgent and cannot wait until the office is open. Medication refills/ pre- authorizations/scheduling appointments **are not considered emergencies**, so please do not have the doctors paged for such services.

**Payment for the services:** Payment for the service is due at the time of service. Any past due balance needs to be paid before the next visit. We may need to cancel your appointment if you are unable to pay your balance in full prior to your next visit. We will send two monthly statements and one final collection letter and if the balance is unpaid, it may be turned over to outside collection agency. If you are unable to pay your balance in full, we can offer you a "No interest" payment plan where the minimum payment should be \$100 per month and/or balance will have to be paid off in six installments / six months. First payment is due on the day payment plan is set up. Payment on the payment plan statements will be considered separate than you current visit costs which needs to be paid at time of service, regardless of your payments towards payment plan.

**Credit Card on file policy:** We require keeping your credit or debit card on file as a convenient method of payment for the portion of services that your insurance doesn't cover, but for which you are liable. Without this authorization, a billing fee of \$25 will be added to your account for any balances that we must attempt to collect through mailing monthly statement. Furthermore, an "outstanding balance" charge of 1.5 percent of the total bill will charge for each month that the bill remains unpaid. Your credit card information is kept confidential and secure and payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to the account.

Patients with insurance plans under Obamacare / Affordable Care Act, will have to pay the full visit cost upfront for each visit. We will bill your insurance, and if the insurance pays for the visit and doesn't ask for refund/recoupment in 4 months after your visit, we will refund you the credit.



### Other Fees

Medical records, disability forms, work excuses, school notes, calls to employers, return to work letters, etc. will be provided on a fee basis. **The fee must be prepaid in order for us to complete the requested task.** The fee will be based on time spent preparing the requested information.

**Medical Records:** There will be a charge of \$40.00 for the first 20 pages and \$1.00 per page for every copy thereafter for medical records. In addition, a reasonable fee may include actual costs for mailing, shipping, or delivery. **Please note it will take 7-10 business days for processing the records.**

**Letters/ Documentation:** There is a charge associated with any and all documentation that we may have to complete. The charges will be determined by the amount of time spent to complete the request.

**FMLA/Disability Paperwork:** We **DO NOT** do FMLA/Disability paperwork. In rare case, if we fill out FMLA/Disability paperwork, there will be a charge of \$40 that you will have to pay. We will not be able to bill your insurance or your employer for that.

**Court Fees:** If a deposition or opinion in court is required, there is a \$300 per hour charge for the Nurse Practitioner and \$500 per hour for the MD/PhD to go to court. The minimum charge is \$1000 paid in advance. The hourly charge is billed for preparation time, travel time, and any time spent with an attorney/ clerk for preparation. Travel costs (i.e. tolls, gas, and miles) will also be billed to you. Your insurance company will not be billed for any of these fees and you are solely responsible for them.

**All fees, including late cancellation and no show fee, are not final and subject to change at any time without notice based on the discretion of the practice.**

I have read, understood, and agreed to the policies listed above for Psychiatric Medical Associates. I accept the conditions for receiving service from the providers at Psychiatric Medical Associates, PA.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_



By the signature below, I hereby authorize Psychiatric Medical Associates to **release and obtain** information with respect to any **physical, psychiatric, or drug/alcohol related condition** obtained during the course of diagnosis and/or treatment **to/from** individual(s) or healthcare provider(s) below. The type of information authorized includes, but may be limited to, that which is indicated below.

<b>RELEASE TO/OBTAIN FROM</b>		<b>INITIAL EACH SPECIFIC CONSENT TO RELEASE</b>
By identifying and initialing below you are giving the provider permission to <b>release and/or obtain psychiatric evaluation, reports of testing, most recent progress notes, treatment plans, medications, and lab reports.</b>		
<b>Family Members or Significant Others</b>	Name/Relationship:	<input type="checkbox"/> Yes <input type="checkbox"/> No Initial _____
	Contact Number:	
	Name/Relationship:	
	Contact Number:	
<b>School RN/School Counselor</b>	Name:	<input type="checkbox"/> Yes <input type="checkbox"/> No Initial _____
	Contact Number/Fax:	
<b>Therapist/Counselor</b>	Name:	<input type="checkbox"/> Yes <input type="checkbox"/> No Initial _____
	Contact Number/Fax:	
<b>PCP</b>	Name:	<input type="checkbox"/> Yes <input type="checkbox"/> No Initial _____
	Contact Number/Fax:	
<b>Employer/HR Department</b>	Name:	<input type="checkbox"/> Yes <input type="checkbox"/> No Initial _____
	Contact Number/Fax:	
<b>Attorney</b>	Name:	<input type="checkbox"/> Yes <input type="checkbox"/> No Initial _____
	Contact Number/Fax:	
<b>Tx Dept of Family and Protective Services CPS</b>	Case Manager Name:	<input type="checkbox"/> Yes <input type="checkbox"/> No Initial _____
	Contact Number/Fax:	
<b>Other</b>	Name/Relationship:	<input type="checkbox"/> Yes <input type="checkbox"/> No Initial _____
	Contact Number/Fax:	

I understand that this authorization is voluntary and made at my discretion. I may cancel/revoke this authorization at any time by giving written notice of my desire to do so. **By initialing and signing I have given consent for both verbal and medical records to be released to/obtained from the identified individuals.**

\_\_\_\_\_  
Patient Name    Patient Signature    Date of Birth

\_\_\_\_\_  
**Signature of parent, guardian or authorized representative (if applicable)**    Date



**CREDIT CARD ON FILE POLICY**

At Psychiatric Medical Associates, P.A., we require keeping your credit or debit card on file as a convenient method of payment for the portion of services that your insurance doesn't cover, but for which you are liable. Without this authorization, a billing fee of \$25 will be added to your account for any balances that we must attempt to collect through mailing monthly statement. Furthermore, an "outstanding balance" charge of 1.5 percent of the total bill will charge for each month that the bill remains unpaid.

Your credit card information is kept confidential and secure and payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to the account.

**I authorize Psychiatric Medical Associates, P.A. to charge the portion of my bill that is my financial responsibility to the following credit or debit card:**

Visa  MasterCard  Discover  American Express

**Credit Card Number** \_\_\_\_\_

**Expiration Date** \_\_\_\_/\_\_\_\_/\_\_\_\_ **CVV # (Security code on back of card)** \_\_\_\_\_

**Cardholder Name** \_\_\_\_\_

**Billing Address** \_\_\_\_\_

**City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Signature** \_\_\_\_\_

I (we), the undersigned, authorize and request Psychiatric Medical Associates, P.A. to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility. This authorization relates to all payments not covered by my insurance company for services provided to me by Psychiatric Medical Associates, P.A.

This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 60 day notification to Psychiatric Medical Associates, P.A. in writing and the account must be in good standing.

**Patient Name (Print):** \_\_\_\_\_ **Legal Guardian Name (Print):** \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ **Legal Guardian Signature:** \_\_\_\_\_

**Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_