St. Remi Behavioral Health
Dr. Isiaka Bolarinwa- Board Certified Psychiatrist
822 Klemm Ave.
Gloucester City, NJ 08030
Phone: 856-282-5566 ~ Fax: 856-396-9917

Date:________________

PATIENT INFORMATION

Last Name:**___________________________First Name:**_________________________________ **Middle Initial:**_____________

***Address:**____

City:_________________________________**State:**____________________________**Zip:**_____________________________

Phone Number:**__________________________SSN:**____________________________***DOB:**_____________________________

Age:________________**Sex:**_________________**Martial Status:**______________________

Employer Name and Address:____

Work Phone #:____ ***Email:**____

Emergency Contact:_______________________________________***Phone Number:**______________________________________

GUARANTOR INFORMATION: (List person or insured name responsible for bill: full legal name)

Relationship of Guarantor to Patient: **Self**_______________ **Spouse**_____________ **Parent**_____________ **Other**_____________

Last Name:____**First Name**:______________________________**Middle Initial:**____________

Address:____

City:____ **State**:__________________________________**Zip:**___________________________

Phone Number:____ **Social Security:** ____

Date of Birth:____ **Age**:______________________ **Sex:**___________________________

Employer Name and Address:____

____**Phone Number:**____

INSURANCE INFORMATION: (Please allow receptionist to photocopy your insurance ID cards)

PRIMARY INSURANCE:

Plan Name:____ Insured's Name:_____________________________________

Insured's Social Security #:_________________________________ Insured DOB:____

Policy/ID #:_______________________________ Group #:________________________ EFF Date:___________________________

Claims Address & Phone:____

SECONDARY INSURANCE:

Plan Name:____ Insured's Name:_____________________________________

Insured's Social Security #:_________________________________ Insured DOB:____

Policy/ID #:_______________________________ Group #:________________________ EFF Date:___________________________

Claims Address & Phone:____

***REQUIRED FIELDS- PLEASE COMPLETE FOR BILLING** ***ATTACH COPY OF INSURANCE CARDS**

PATIENT REGISTRATION

Patient Name: ___________________________________

Reason seeking treatment:____
____

Previous Psychiatrist: ____
Address:____ **Phone:** ______________________________

Most Recent Psychiatric Inpatient Hospitalization: ____
Facility Name:_______________________________**Address:** _______________________________________

PCP: ____

Address:____**Phone:**__________________________

Pharmacy:____ **Phone:** _________________________

Address:____

Current Medications

Medication	Dosage/Frequency	Length on Med	Reason	Prescriber
	/			
	/			
	/			
	/			
	/			
	/			

St Remi Behavioral Health

822 Klemm Ave,

Gloucester City, NJ 08030

Financial Responsibility

Thank you for choosing St Remi Behavioral Health, for your Mental Health needs. We are committed to providing excellent care. As part of our professional relationship, it is important for you to understand our financial policies.

As a courtesy to patients, St Remi Behavioral Health submits claims to most insurance carriers. **To ensure proper and prompt processing of your claim, it is important that you provide a current insurance card and your driver's license or other form of identification at the time of registration.**

We attempt to verify your insurance benefits prior to medical services being completed. Estimates of your financial responsibility are based on the accuracy of this information. The insurance benefit information provided by your insurance plan is based on the latest information they have available. Please remember that your insurance plan benefits are a contract between you, your employer and your insurance company. It is in your best interest to know and understand your benefits.

Please inform us of any demographic and insurance changes. If your insurance has changed or you have more than one policy please inform the receptionist, and provide them the insurance cards. If changes in your insurance information coverage is not provided or received within the insurance carrier's timely filing period, the patient will become responsible for any balance on the account.

Deductibles, Co-ins and Co-pays are always due prior to service. No exceptions.

There is a $25 administrative charge for all office letters.

Self-pay: Please see the receptionist for self pay rates and payment options. If any tests or procedures are recommended by the provider, you will be notified in advance in order to make an informed decision. Self pay patients are required to pay upfront and in full prior to service.

Balance Due after insurance payment: We will send a statement to your billing address notifying you of any balances due. Any unpaid balance is the patient's responsibility and payment in full is due upon receipt of the statement. Payment not made within 30 days of the statement issue date is deemed past due. Past due accounts are subject to a $25.00 monthly late fee. Payments not received within 60 days of the statement date will be sent to the collection agency and/or attorney. You will be responsible for all collection costs incurred, including attorney's and court fee, if applicable. If you are unable to pay the balance due in full, you must contact our billing office to discuss possible payment options.

We accept the following type of payment: Cash, Check

If your account is assigned to a professional collection agency, you will no longer be able to receive services from the providers at St Remi Behavioral Health, until your delinquency is cured. Thereafter, any future services rendered will require that you pay upfront and in full prior to service. If your statement balance is paid by check and the check return unpaid by your bank for any reason, a $50.00 returned check fee will be added to your account and the past due policy above will also be reactivated.

Your signature below is an attestation to the above policy.

____

Patient/Guardian Print Name

____ _______________________________

Patient/Guardian Sign Date

Appointment Cancellation/No Show Policy

We understand there are times when you must miss an appointment due to an emergency or previous obligation. However, when you do not call to cancel an appointment you are preventing another patient from receiving an appointment or if another patient fails to cancel it could prevent you from receiving an appointment due to a seemingly "full" schedule.

In order to provide the best possible care in a timely fashion we have developed policies for cancellations and no-show appointments. Appointments are in high demand; please make every attempt to come in for your scheduled appointment or cancel accordingly.

Cancellations

If an appointment is not canceled by 2pm the day prior to the appointment, it will be considered a "LATE CANCELLATION". **3 late cancellations in 6 months will result in discharge from the practice.**

No Show

If a patient does not call nor show up for their scheduled appointment it will be considered a "NO SHOW".
2 NO SHOWS will result in discharge from the practice

I have read and understand the appointment cancellation/no show policy; I agree to the terms of this policy.

Signature: ____Date:_________

Print Name:____

St. Remi Behavioral Health
Medication Informed Consent

AUTHORIZATION TO RELEASE INFORMATION : I/We hereby authorize St Remi Behavioral Health to release any medical or incidental information that may be necessary for medical benefit or in processing applications for financial benefit. This includes but is not limited to my insurance company, Rehabilitation Services, Social Security Administration, and Worker's Compensation.

CONSENT FOR TREATMENT : I/We hereby authorize St Remi Behavioral Health to administer diagnostic and medical procedures as may be necessary for proper health care.

OFFICE POLICY ON PAYMENT: I understand that I am responsible for all charges. As a courtesy, my insurance will be billed for me. It is my responsibility to pay any deductible, copay and any other balance not paid for by my insurance company. I authorize insurance benefits to be paid directly to St Remi Behavioral Health.

MEDICARE/MEDICAID AUTHORIZATION : I request that payment of authorized Medicare benefits be made to me or on my behalf to St Remi Behavioral Health for services furnished to me by the provider. I authorize any holder of medical information about me to release to the Center for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

MEDIGAP AUTHORIZATION (secondary to medicare) : I request that payment of authorized Medigap benefits be made either to me or on my behalf to the provider of service and (or) supplier for any services furnished to me by the provider of service and (or) supplier. I authorize any holder of Medicare information about me to release to (name of Medigap Insurer) any information needed to determine these benefits payable for related services.

Signature:____**Date:**____________________

Print Name:____

Patient Name:____

DOB:_____________________________________

I have received and reviewed medication information sheets, and/or verbal counseling regarding the following medications including associated risks, benefits and alternatives:

I have been given the opportunity to discuss my questions and/or concern about these medications with both the Psychiatric staff and the Psychotherapy staff at St. Remi Behavioral Health.

Please initial:

______I hereby agree to take the following medications as prescribed by the St Remi Behavioral Health psychiatric staff:

______I hereby do not agree to take the following medications as prescribed by the St Remi Behavioral Health psychiatric staff:

Do you want your family or other caregivers to receive information regarding your medications?

YES NO

Provide Name / Phone Number:

____ ____

____ ____

____ ____

Client Signature:____Date:_______________________

Psychiatrist:____Date:_______________________

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AUTHORIZATION TO OBTAIN MEDICAL RECORDS FROM PRIMARY DOCTOR

PLEASE SELECT ONE OPTION

Do you want St. Remi to retrieve medical records from your primary doctor?

YES NO

If YES, please fill out the authorization form to release the medical information form attached to this packet and send it back to Practice via mail or fax for records retrieval?

Name:____Date:________________________

Sign:____