Immediate Care Psychiatric Center – NJPsychCenter

Morris County:	Bergen County:
22 Hill Road	140 Route 17 North Suite 317
Parsippany, NJ 07054	Paramus, NJ 07652
Tel: (973) 335-9909	Tel: (201) 984-9373

PATIENT REGISTRATION
PLEASE PRINT

PATIENT INFORMATION

LAST NAME	FIRST	MI	ADDRESS

CITY	STATE	ZIP CODE	SEX	HOME PHONE	CELL PHONE	DATE OF BIRTH

SOCIAL SECURITY NO.	AGE	MARITAL STATUS 1SINGLE 1MARRIED 1OTHER	FAMILY PHYSICIAN

EMPLOYER	ADDRESS	CITY	STATE	ZIP	TELEPHONE

*****PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED, UNLESS YOU ARE ENROLLED IN AN INSURANCE PROGRAM WE ARE PARTICIPATING WITH OR PREVIOUS PAYMENT ARRANGEMENTS HAVE BEEN MADE******

REFERRED BY

NAME	ADDRESS	TELEPHONE

POLICY HOLDER

LAST NAME IF DIFFERENT	FIRST NAME	MI

BIRTH DATE	SEX	RELATIONSHIP	SOCIAL SECURITY

EMPLOYER	TELEPHONE

ADDRESS

IN CASE OF EMERGENCY

NAME
ADDRESS
TELEPHONE
RELATIONSHIP

PLEASE COMPLETE THE FOLLOWING INFORMATION SO WE MAY MAINTAIN OUR FILES.

INSURANCE COMPANY INFORMATION

NAME OF PRIMARY INSURANCE COMPANY				NAME OF SECONDARY INSURANCE COMPANY			
ADDRESS				ADDRESS			
CITY	STATE	ZIP	TELEPHONE	CITY	STAT	ZIP	TELEPHONE
INSURANCE ID#		Group#		RELATIONSHIP			

PATIENT EMAIL: ____

I authorize payment of benefits as determined by the Company, directly to:

Physician ____ YES _____ NO

I understand that unless I have checked YES above, benefit payments will be paid to me. I also understand that even if I checked YES above, I may still be responsible for the amounts not paid by insurance company.

X__________________________________DATE ________

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I confirm that I have contacted my insurance co. prior to my visit with ICPC & my insurance carrier informed me that

I do _____ 1 **don't _____ need pre-authorization for mental health services.**

X___________________________________**DATE ________**

MEDICAL RELEASE AUTHORIZATION

Insured party must sign for all claims. Dependent patient must also sign if not a minor. I authorize any insurance company, organization, employer, hospital, physician, dentist or pharmacist to release information requested with regard to processing my claim. I certify that the information I furnish is true and correct. I know that it is a crime to fill out this form with facts I know are false or to leave out facts I know are important. Signature is only good for 30 days. It is ICPC policy not to fax completed medical records to the physician to maintain confidentiality.

YES

X___________________________________DATE ________

NO, I do not wish to release my medical records

X___________________________________DATE ________

I understand that a *<u>24-Hour Cancellation*</u> notice for appointments is required and if I fail to do so I will be held responsible for $50.00 late fee.

I also agree and understand that I must provide any changes regarding my insurance policy, address and telephone numbers for proper billing procedures. If I fail to provide current information I will be held responsible for the full service charge.

X ____ DATE _________

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1. Allergies -are you allergic to any medication or food Yes o No o If yes, please indicate____________________________

2. Do you currently have any medical conditions Yes o No o If yes, please indicate___________________________

3. Are you now under a physician's care? Yes o No o

   Physician's Name __________________________________ Reason for Care ______________________

4 Have you been treated for any of the following? No o Yes o if yes, please circle:

Diabetes	Epilepsy	Thyroid	Prolonged Bleeding
Anemia	Gout	High Blood Pressure	Rheumatic Fever
Arthritis	Glaucoma	Kidney Problem	Stroke
Asthma	Heart Problems	Liver Problems	Tumors
Cancer	Hepatitis	Nervousness	Ulcers
Anorexia	Bulimia	Binge Eating	Hypoglycemia

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Medication checklist (Please list all current medications)

Medication	Dosage	Frequency
______________________	_______________	_______________
______________________	_______________	_______________
______________________	_______________	_______________
______________________	_______________	_______________
______________________	_______________	_______________
______________________	_______________	_______________
______________________	_______________	_______________
______________________	_______________	_______________
______________________	_______________	_______________

In the event you are prescribed any medications, it is strongly encouraged that you share this information with your primary care physician or pediatrician.

If you are prescribed any psychotropic medications, your physician will discuss all risks and benefits associated with it, as well as possible alternatives or choosing no treatment at all.

You may be asked to obtain bloodwork and/or other testing from your primary care physician or pediatrician prior to and/or while being prescribed medications.

Preferred Pharmacy Name: ____

Location: ____

Phone number: ____

Patient Signature ____________________________ Date____ /_____/_____