**Personal Information Form**

Patients Name:     Guardians Name: Today's Date:

Date of Birth: Email:

SS#:

Address: Phone: (cell)

Primary Medical Doctor:   Last Physical:

Emergency Contact#:  Relationship:

Medical History (including surgeries):

Allergies:

Medications:

Occupation:

Marital Status: *Single Married Divorced Separated Other*

Alcohol:  Drugs:  Tobacco:

Family Psychiatric HX:

Past Psych HX:  Hospitalizations: *YES NO*  Suicide Attempts:  *YES NO*

Past Psych Medications/Treatment:

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**CREDIT CARD AUTHORIZATION FORM**

I appreciate the trust that you place in me to provide you with psychiatric care and services. Please understand that your benefit plan is an arrangement that involves you and your insurance carrier.

In order for my practice to run smoothly and continue to offer you high quality care, I respectfully request that you sign below to authorize Dr. Cohen to keep your signature on file and charge your credit card for balances of charges that are not paid, including cancellation charges where applicable. I will automatically charge your credit card the fee for appointments that are not cancelled 48 hours in advance.

Thank you for your cooperation.

Date:

Name on card:

*please print clearly*

Card type (*please circle one*):

*Visa MasterCard American Express*

Credit Card Number:

Expiration Date:

Security Code:

Card Holder Signature:

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**PATIENT POLICIES**

**Payment Policies**:

Payment for services is due at the time of service.

A credit card will be held on file for all outstanding charges. You will receive a courtesy Email or phone call to let you know about your balance. If we do not get a response from you within 24 hrs, your card will automatically be charged.

Unless arrangements are made for a payment plan, all accounts that are outstanding for more than 60 days will be sent to a collection agency.

**Appointment Cancellations**:

A cancellation within 24 hours of the scheduled appointment or a no show will result in the patient being responsible for the FULL cost of the visit and will be automatically charged to the card we have one file for you.

NO prescriptions will be called into the pharmacy without an appointment (some exceptions will be made in rare cases).

If you miss an appointment and we do not hear from you within one month we will assume you will not be returning to the office and your chart will be closed. You are welcome to come in again for an evaluation.

**Phone Calls**:

Phone calls requiring more than a few minutes time will be billed according to the doctor's hourly rate.

**Letter Requests**:

Time spent on requests for letters will be billed according to the doctor's hourly rate.

***By signing this form you agree to all of the terms listed above***.

SIGNATURE:

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