Psychiatric Medicine Center, LLC

5 Shaws Cove, Suite 207, New London CT, 06320

•P-(860) 444-8877 • F-(860)444-9660• E- HenryCrabbeMD@gmail.com

PATIENT REGISTRATION FORM

Date: _____

Demographic Information

Last Name: _____ **First Name:** _____**MI**: _____

Mailing Address: _____ **City:** _____ **State:** ____ **Zip:** _____

Cell Phone: _____ **Alt Phone:** _____

Date of Birth _____ **Age**: ____ **Sex**: Male/Female/Other/Prefer Not to Answer

SSN# _____ **Marital Status:** Single/Married/Divorced/Widowed

E-Mail Address: _____

Emergency Contact: _____ **Relationship:** _____
Phone_____

Insurance Information

Primary Insurance Company: _____ Insurance Policy Holder: ☐ Self ☐ Other

Secondary Insurance Company: _____ Insurance Policy Holder: ☐ Self ☐ Other

Please provide the name and date of birth of the policy holder if you selected "Other" above

Policy Holder Name: _____ Date of Birth: _____ Relationship: _____

Medical History

Have you ever been diagnosed with/treated for any of the following health conditions? (circle all that apply)

Alcoholism/Addiction
Asthma
Emphysema (COPD)
High Blood Pressure
High Cholesterol
Renal (kidney) Disease
Thyroid Disease
Heart Disease
Stroke
Cancer

Behavioral Health History

Have you ever been diagnosed with/treated for any of the following mental health conditions? (circle all that apply)

Depressive Disorders
Bipolar/Other Mood Disorders
Anxiety Disorders
Obsessive-Compulsive Disorder
Posttraumatic Stress Disorder
Eating Disorders
Substance Use Disorders
Sleep Disorders
Schizophrenia Disorder
Attention-Deficit/Hyperactivity Disorder (ADHD
Other: _____

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Financial Policy Agreement

All services are provided by Psychiatric Medicine Center, LLC (PMC) / Henry Crabbe, MD. Payment for all services is due at the time of your appointment unless otherwise specified. If you have insurance, any required co-payment, co-insurance, or deductible is due at the time of service. If Henry Crabbe, MD is not in network with your insurance plan, out of network fees may apply.

You are responsible for confirming your insurance coverage and network status prior to your appointment, and for notifying the office of any changes to your insurance before you are seen. If your insurance denies a claim due to inactive coverage, out-of-network status, or missing information, you will be responsible for the full balance.

After insurance claims are processed, any remaining balance will be billed to you and mailed to the address on file. Payment is due by the date listed in your statement. You may request to receive electronic invoices by email or text message through our payment processor Square. If you require a payment plan, you must contact the office to make arrangements. Failure to pay outstanding balances or to communicate with the office regarding your balance may result in cancellation or suspension of future appointments until your balance is paid in full.

Payments may be made by credit card, debit card, check, or electronic payment. A $50 fee will be charged for any returned check or disputed card payment.

Appointment Cancellation, No-Show, and Late Arrival Policy

You are required to notify the office at least 24 hours in advance if you need to cancel or reschedule your appointment. Notice may be given by text message or by calling the office. If you cancel by text, you are responsible for contacting the office directly to reschedule. Please plan to arrive on time for all scheduled appointments, whether in person or by telehealth. If you arrive more than 10 minutes late, your appointment may need to be rescheduled. *Frequent cancellations or missed appointments may result in discharge from the practice for non-compliance*. The office makes every effort to stay on schedule, but occasional delays may occur.

Discharge Policy

At the discretion of Henry Crabbe, MD, you may be discharged from the office and your insurance may be notified for any of the following reasons:

Repeated failure to follow the recommended treatment plan or medical instructions, including the Controlled Substance Agreement if applicable, failure to meet financial responsibilities, the office is unable to provide the level of care necessary to meet your needs, abusive or inappropriate behavior toward the provider or office staff.

Confidentiality Policy

The office is committed to protecting your privacy and maintaining the confidentiality of your personal health information in accordance with state and federal laws. Your records and any information you share during treatment are kept strictly confidential. Information about your care will not be disclosed to anyone outside the office without your written consent, except as required or permitted by law. This may include situations such as suspected abuse or neglect, threats of harm to yourself or others, medical emergencies, or as required by a court order or legal process. The office follows all guidelines under the Health Insurance Portability and Accountability Act (HIPAA)

and applicable Connecticut state laws regarding mental health records. If you have questions about your privacy rights or how your information may be shared, please ask the office for more information. PMC may have access to your prescription history from other providers through electronic medical and pharmacy records. To protect the privacy of all parties, patients are not permitted to audio or video record any session, appointment, or communication with the provider or office staff at any time.

After-Hours and Emergency Services

PMC is outpatient practice and does not provide emergency or crisis services. If you are experiencing a medical or psychiatric emergency, call 911 or go to the nearest emergency room immediately. Emergency psychiatric care is available at all hospital emergency departments without an appointment.

Electronic Communication and Appointment Reminders

Appointment reminders are automatically sent by text message at the time your appointment is made and again 24 hours before your appointment. However, it is your responsibility to know the date, time, and location of your appointment, regardless of whether you receive a reminder. You may decline or revoke consent for text message reminders at any time by notifying the office in writing.

Please be aware that while the office takes reasonable precautions to protect your privacy, electronic communication, including text messages and emails, may not be completely secure. By choosing to communicate or receive billing and appointment reminders electronically, you acknowledge and accept these risks. The office is not responsible and cannot be held liable for any breach of confidentiality or unauthorized disclosure that occurs during electronic transmission.

Information About Psychiatric Care

What Is Psychiatric Care?

Psychiatric care includes the evaluation, diagnosis, and medical treatment of mental health conditions, most often through psychiatric medication management. Below are common possible benefits and risks associated with medication management:

Possible Benefits: Reduction of symptoms, improved daily functioning and quality of life.

Possible Risks: Medication side effects/interactions, no improvement, possible worsening of symptoms, rare risk of new or increased mood symptoms, including suicidal thoughts.

Risks of Refusing or Stopping Treatment: Worsening symptoms, decline in daily functioning/quality of life, increased risk of serious health or safety concerns, including suicidal thoughts.

If you have questions about your treatment or other options, please discuss them with Dr. Crabbe at any time. You have the right to be involved in decisions about your care.

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Signature and Acknowledgment

By signing below, you acknowledge and agree to the following:

- The information you have provided is accurate to the best of your knowledge.
- You voluntarily consent to receive psychiatric evaluation and treatment from Psychiatric Medicine Center, LLC (the office) / Henry Crabbe, MD, and understand the nature, risks, and benefits of psychiatric care, including the risks and benefits of refusing or discontinuing treatment. You understand that you may ask questions or request information about alternative treatment options at any time.
- You authorize your insurance benefits to be paid directly to Henry Crabbe, MD, and understand you are financially responsible for any charges not covered by your insurance. You authorize the office or your insurance company to release any information necessary to process your claims.
- You have received and reviewed the office's policies, including financial policies, fees, appointment cancellation/no-show/late arrival, discharge, confidentiality, electronic communication, and other office procedures, and you agree to abide by these policies during your care. You understand that office policies may be updated and that you may review the most current policies on request or on the office website.
- You acknowledge receipt of the office's Notice of Privacy Practices, which explains how your health information may be used or disclosed. You understand you may request a copy of this Notice at any time.
- You consent to receiving appointment reminders and billing notifications via text message and/or email, understanding the risks and limitations of electronic communications. You may withdraw this consent in writing at any time.

You understand that your signature below applies to all agreements and policies contained in this paperwork.

Your signature below confirms that you have carefully read, understood, and agree to all terms outlined above and within the office policies and forms.

☐ **I consent** to receiving electronic invoices by text or email

☐ **I do not consent** to receiving electronic invoices by text or email

_____	_____	_____
Patient Name	Patient Signature (Legal Guardian Signature if Applicable)	Date

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TELEHEALTH CONSENT FORM

Telehealth appointments allow you to receive psychiatric care with Dr. Crabbe using a secure video or telephone instead of an in-person visit. By consenting to telehealth, you acknowledge and agree to the following:

Telehealth visits require that you participate from a private, secure location where your personal information cannot be overheard or accessed by others. It is your responsibility to ensure the privacy of your setting. The office is not responsible for any loss of privacy or unauthorized disclosure that occurs due to your choice of location or the presence of others.

Telehealth appointments may not be conducted at your place of employment or any public location. You must use your own personal phone or device; the office cannot call your work number or a friend's or family member's phone for appointments.

You understand that technical problems may occur during telehealth appointments, and that confidentiality protections are in place for all electronic communications. You have the right to ask questions about telehealth at any time and may withdraw your consent or request in-person appointments at any point without penalty to your care.

Please check one:

☐ **I consent** to telehealth appointments (video or phone) and agree to the conditions above

☐ **I <u>do not</u> consent** to telehealth (video or phone) appointments

_____ _____
Patient Name Signature

_____ _____
Legal Guardian Name/Signature (If applicable) Date