Psychiatric Medicine Center, LLC

Henry F. Crabbe Ph.D., M.D.
5 Shaw's Cove, Suite 207, New London, CT 06320

New Patient Registration Form

Date: _____/_____/ 2026__

Demographic Information

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

Mailing Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Primary Phone: _____ **Secondary Phone:** _____

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

SSN #: _____-_____-_____ **Marital Status:** Single/ Married/ Divorced/ Widowed/ Partnered/ Other
(SSN will not be shared-for insurance purposes only)

Primary Care Provider: _____ **Phone:** _____

E-Mail Address: _____@_____
(This is required to sign up for our patient portal)

Occupation:_____

Emergency Contact:_____ **Relationship:**_____

Phone Number: _____

Medical History:
Please circle all that apply past or present

Alcoholism/Addiction	GERD	Migraines
Anemia	Heart Disease	Thyroid Disease
Asthma	High Blood Pressure	Stroke
Cancer (Specify: _____)	High Cholesterol	Other: _____
Diabetes (Type 1/ Type 2)	HIV/AIDS	
Emphysema (COPD)	Kidney Disease	
Epilepsy/Seizures	Liver Disease	

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Behavioral Health History:

Please circle all that apply past or present

ADHD	Eating Disorder	Schizoaffective Disorder
Anxiety Disorder	OCD	Substance Use Disorder
Bipolar Disorder	Panic Disorder	Sleep Disorders
Depressive Disorder	PTSD	Other:_____

Behavioral Health Questionnaire:

Have you ever been psychiatrically hospitalized?

☐ Yes ☐ No

If yes, please provide approximate date(s) and reason(s):

Do you have a history of self-harm or self-injurious behavior?

☐ Yes ☐ No

Have you ever had a suicide attempt?

☐ Yes ☐ No

If yes, approximate date(s): _____

Are you currently seeing a therapist, counselor, or other behavioral health provider outside of this practice?

☐ Yes ☐ No
If yes, Provider Name: _____

Have you previously received treatment for alcohol or substance use?

☐ Yes ☐ No

If yes, please explain:

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Medications and Pharmacy

New patients: *Please list all medications you are currently taking. Including over-the-counter medications and supplements*

Established patients: *If there have been no changes to your current medications, you may leave this section blank.*

Medication Allergies: _____

Reactions: _____

☐ **No Known Drug Allergies**

Current Medications:

Medication Name:	Dosage:	Frequency:	Reason/Condition:

Preferred Pharmacy: _____ **City:** _____

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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, referral requirement, 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. 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 fee may be assessed for a returned checks, as permitted by applicable law.

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, the provider-patient relationship may be terminated for reasons including, but not limited to:

- Repeated failure to follow the recommended treatment plan or medical instructions
- Failure to comply with the Controlled Substance Agreement, when applicable
- Repeated missed appointments or cancellations

- Failure to meet financial responsibilities or communicate with the office regarding outstanding balances
- Abusive, threatening, disruptive, or inappropriate behavior toward the provider or office staff
- The practice determining that it is unable to provide the level or type of care necessary to appropriately meet the patient's clinical needs.

Confidentiality Policy

Your records and information shared during treatment are maintained confidentially in accordance with applicable state and federal law. 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 an 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 Scheduling

As a courtesy, the office will generally schedule your next follow-up appointment after your telehealth visit with Dr. Crabbe and send the appointment information to you by text message. While we make every effort to ensure follow-up appointments are scheduled, an appointment may occasionally be missed during the scheduling process. It is ultimately the patient's responsibility to ensure that a follow-up appointment has been scheduled. **If you do not receive a text message confirming your next appointment, you should assume that an appointment has not been scheduled and contact the office.**

Although the office takes reasonable precautions to protect your privacy, text messages and email may not be completely secure. By choosing to communicate with the office electronically, you acknowledge and accept the potential privacy risks associated with electronic communication.

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Signature and Acknowledgement

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

- The information you provided is accurate to the best of your knowledge.
- You voluntarily consent to receive a psychiatric evaluation and treatment from Psychiatric Medicine Center, LLC/Henry Crabbe, MD, and understand the nature and 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 Psychiatric Medicine Center, LLC/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 reviewed the office's policies, including financial policies, fees, appointment cancellation/no-show/late arrival, discharge policies, confidentiality, electronic communication and other office procedures, and you agree to abide by these policies during your care.
- You acknowledge receipt of the office's Notice of Privacy Practice, 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 communication/appointment/billing notifications via text message and/or e-mail, understanding the risks and limitations of electronic communications. You may withdraw your consent at any time in writing.

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 communications by text and/or e-mail

☐ I do not consent to receiving electronic communications by text or e-mail

Patient Name: _____ Date: _____

Signature: _____

Telehealth Consent Form

Psychiatric Medicine Center, LLC

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Telehealth Consent Form

Telehealth allows you to receive psychiatric medication management from Dr. Henry F. Crabbe through secure video or telephone communication instead of an in-person office visit. By consenting to telehealth services, you acknowledge and agree to the following:

Privacy and Location:
You must participate in telehealth appointments from a private, secure location where your personal and medical information cannot reasonably be overheard or accessed by others. Telehealth appointments may not be conducted from your place of employment or a public location. You must use your own personal telephone or device and may not use a work telephone or another person's telephone for appointments. You are responsible for choosing a private setting and taking reasonable steps to prevent others from overhearing or accessing your appointment. The practice cannot ensure confidentiality when you choose to participate from a location where other individuals are present or able to overhear the session.

Identification and Emergency Location:
At the beginning of each telehealth appointment, you may be asked to confirm your identity, current physical location, and a telephone number where you can be reached. You agree to provide accurate information so that emergency assistance may be contacted if necessary.

Other Individuals Present:
You must inform Dr. Crabbe if another person is present or able to hear the telehealth appointment. Dr. Crabbe may request that other individuals leave the area when necessary to protect your privacy or allow for an appropriate clinical assessment.

Technology and Connection Problems:
You understand that technical difficulties, interruptions, or failures may occur during telehealth appointments. If the connection is interrupted or cannot be established, the office may attempt to contact you by telephone. Depending upon the circumstances, the appointment may continue by telephone when clinically appropriate or may need to be rescheduled. **If you miss a phone call from Dr. Crabbe for your telehealth visit, please call the office back and leave a voicemail if you are unable to speak with the receptionist**.

Clinical Limitations:
Telehealth may not be appropriate for every patient or every clinical situation. Dr. Crabbe may determine that an in-person appointment, additional evaluation, emergency assessment, or a different level of care is necessary based upon your clinical condition or treatment needs.

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Medication and Prescribing:
Participation in a telehealth appointment does not guarantee that any medication or controlled substance will be prescribed or refilled. All prescribing decisions remain at the clinical discretion of Dr. Crabbe and are subject to applicable federal and state laws and practice policies. An in-person evaluation may be required when clinically or legally necessary.

Recording:
Telehealth appointments may not be photographed, audio recorded, video recorded, screen recorded, livestreamed, or otherwise reproduced by the patient or any other person without the prior consent of Dr. Crabbe.

Emergencies:
Telehealth is not intended for emergency or crisis services. If an emergency or safety concern arises during a telehealth appointment, Dr. Crabbe may contact emergency services, your emergency contact, or other appropriate individuals or agencies when necessary to protect your safety or the safety of others. If you are experiencing an immediate psychiatric or medical emergency outside of an appointment, call 911 or go to the nearest emergency department.

You understand that confidentiality protections apply to telehealth services and that there are potential risks associated with electronic communication and technology. You have the right to ask questions regarding telehealth services at any time. You may withdraw your consent to telehealth services and request an in-person appointment; however, the availability and clinical appropriateness of an in-person appointment will be determined by the practice.

PLEASE CHECK ONE:

☐ **I CONSENT** to receiving psychiatric evaluation and/or treatment through telehealth (video or telephone). I acknowledge that I have read and understand the information above, have had an opportunity to ask questions, and voluntarily consent to telehealth services.

☐ **I DO NOT CONSENT** to telehealth (video or telephone) appointments.

Patient Name: _____

Patient Signature: _____ **Date:** _____

Legal Guardian Name (if applicable): _____

Legal Guardian Signature: _____ **Date:** _____