

RIVER CITY PSYCHIATRY

4201 Springhurst Blvd, Suite 203
Louisville, Ky. 40241
Phone: (502) 425-6690
Fax: (502) 425-6629
www.RiverCityPsychiatry.com

Thank you for choosing River City Psychiatry for your mental health needs. Enclosed are complete instructions for what you will need to do before your appointment. Please fill out everything completely in order to maximize the time you will get to spend with your psychiatrist at your first appointment.

Before Your Appointment

The following things need to be completed and submitted BEFORE your appointment will be scheduled. You can choose to mail, fax, or drop off the completed information (see above for details). Your initial appointment will not be scheduled until this packet is received.

- New Patient Information** – please fill out completely.
 - ✓ At the top of the page, circle which psychiatrist you would like to see. Dr. Ashby sees children and adolescents ages 5 to 17. For an adult psychiatrist, please review our profiles on our website and select the psychiatrist best suited to fit your needs.
 - ✓ We submit prescriptions electronically, so make sure you have the information of the pharmacy you use (name, phone number, and address).
 - ✓ *You must call your insurance company to obtain precertification.* To do so, call the number on back of your card to request. You will need to give them the name of the psychiatrist you are seeing. Write this number as well as the number of visits covered, start date and end date. Also verify your co pay because occasionally for mental health services, this may be different than what is shown on your card. If your insurance company tells you that precertification is not required, write the name of the person you spoke with as well as the reference number on the new patient information form. If your insurance denies a claim due to not having precertification, you may be held responsible for payment in full of the services provided.
- Signature Page** – please sign and return after you have carefully reviewed and understand our “**Policies and Procedures**” as well as our “**Privacy Policy.**” These policies are available for review on our website under “Patient Forms.” Please make sure to thoroughly review these.
- A copy of your insurance card

After we have received all of the above, we will contact the patient to schedule an appointment.

Your First Appointment

- We strongly encourage you to use the “**Driving Directions**” on our website to direct you to our office as GPS/Online maps often lead you to an incorrect location
- Please plan to arrive 10-15 minutes before your scheduled appointment time.
- You must bring your photo ID, insurance card, and any payment. If you have a high deductible insurance plan, and have not met your deductible, you are expected to pay for the appointment prior to seeing the psychiatrist.
- Other things that are important to bring to your first appointment include:
 - A list of your current medications including dose, schedule, frequency
 - Previous treatment records that may be important for us. This would include hospitalization records, psychological testing results, therapy notes, previous treatment records, etc.)
 - A list of all your medical conditions, if any, and medication allergies
- Expect your initial appointment to last up to an hour for adults, an hour and a half for children and adolescents. Follow up visits are typically 15-30 minutes.

DISCLAIMER: A physician patient relationship is not established until completion of your first appointment. You will not be considered a patient of River City Psychiatry or its psychiatrists until then. Completing these forms does not guarantee an appointment. If we determine our services are not adequate to meet the level of care required, we will notify you as soon as possible.

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NEW PATIENT INFORMATION

PREFERRED PSYCHIATRIST (CIRCLE ONE): Ashby (child/adolescent) Thompson Pennington Wozniak No Preference

FIRST NAME _____ LAST NAME: _____ NICKNAME _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PREFERRED PHONE NUMBER: (____) _____ SECONDARY PHONE NUMBER:(____) _____

BIRTHDATE: ____/____/____ RACE _____ SEX _____ MARITAL STATUS _____ SOC SEC # ____ - ____ - ____

EMAIL: _____ EMPLOYER _____

EMERGENCY CONTACT NAME: _____ NUMBER(____) _____ RELATIONSHIP TO PATIENT: _____

HOW DID YOU HEAR ABOUT RIVER CITY PSYCHIATRY? : _____

GUARANTOR/PERSON RESPONSIBLE FOR PAYMENT, IF DIFFERENT FROM ABOVE (FOR PATIENTS UNDER 18, LIST PARENT/GUARDIAN)

NAME: _____ BIRTHDATE: ____/____/____ RELATIONSHIP TO PATIENT: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____ PHONE: (____) _____

PRIMARY INSURANCE COMPANY

NAME OF POLICY HOLDER: _____ BIRTHDATE: ____/____/____ RELATIONSHIP TO PATIENT: _____

ID # _____ GROUP # _____ INSURANCE COMPANY _____ PHONE # _____

PRECERTIFICATION # _____ # VISITS _____ START DATE ____/____/____ END DATE ____/____/____ COPAY \$ _____ DED/COIN _____

IF PRECERTIFICATION NOT REQUIRED, NAME OF REPRESENTATIVE _____ REFERENCE NUMBER _____

SECONDARY INSURANCE COMPANY (IF APPLICABLE)

NAME OF POLICY HOLDER: _____ BIRTHDATE: ____/____/____ RELATIONSHIP TO PATIENT: _____

ID # _____ GROUP # _____ INSURANCE COMPANY _____ PHONE # _____

PRECERTIFICATION # _____ # VISITS _____ START DATE ____/____/____ END DATE ____/____/____ COPAY \$ _____ DED/COIN _____

IF PRECERTIFICATION NOT REQUIRED, NAME OF REPRESENTATIVE _____ REFERENCE NUMBER _____

PRIMARY CARE PHYSICIAN

NAME: _____ PHONE (____) _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

THERAPIST OR OTHER MENTAL HEALTH PROVIDER

NAME: _____ PHONE (____) _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHARMACY INFORMATION

NAME: _____ PHONE (____) _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

REASON(S) FOR SEEKING TREATMENT: _____

CURRENT MEDICATIONS/SUPPLEMENTS/VITAMINS: (Please continue on reverse as needed)

MEDICATION NAME / DOSAGE / SCHEDULE (e.g AM, PM) / REASON FOR TAKING

DRUG/FOOD ALLERGIES: _____

MEDICAL CONDITIONS (CURRENT/PAST MEDICAL PROBLEMS, SURGERIES, HEAD INJURIES, ETC): _____

PAST TREATMENT HISTORY (*please elaborate on any "Yes" responses*):

HAVE YOU EVER SEEN A PSYCHIATRIST BEFORE? Yes No _____

HAVE YOU EVER HAD COUNSELING/THERAPY BEFORE? Yes No _____

HAVE YOU RECEIVED A PSYCHIATRIC DIAGNOSIS? Yes No _____

HAVE YOU EVER BEEN PSYCHIATRICALY HOSPITALIZED? Yes No _____

HAVE YOU TAKEN PSYCHIATRIC MEDICATIONS? Yes No _____

HAVE YOU BEEN DIAGNOSED WITH DEVELOPMENTAL DELAYS? Yes No _____

HAVE YOU BEEN TREATED FOR ALCOHOLISM/SUBSTANCE DEPENDENCE? Yes No _____

HAVE YOU EVER ATTEMPTED SUICIDE OR TRIED TO HARM YOURSELF? Yes No _____

OTHER SIGNIFICANT PSYCHIATRIC HISTORY: _____

IS THERE ANY *FAMILY* HISTORY OF: (PLEASE NOTE RELATIONSHIP TO PATIENT)

DEPRESSION: Yes No _____

BIPOLAR DISORDER OR MANIC-DEPRESSION: Yes No _____

ANXIETY DISORDER: Yes No _____

ADHD: Yes No _____

AUTISM: Yes No _____

OTHER MENTAL ILLNESS: Yes No _____

ATTEMPTED/COMPLETED SUICIDE: Yes No _____

ALCOHOLISM: Yes No _____

SUBSTANCE ABUSE: Yes No _____

OTHER MEDICAL PROBLEMS (HIGH BLOOD PRESSURE, CANCER, SEIZURES, NEUROLOGICAL CONDITIONS, HEART PROBLEMS, DIABETES, ETC) _____

OTHER SIGNIFICANT FAMILY HISTORY: _____



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SIGNATURE PAGE

I have read both pages of "Policies and Procedures" carefully before signing. I agree to abide by the policies as explained. This also serves as my consent for treatment as described in this policy. I understand that submitting information to River City Psychiatry does not establish a physician-patient relationship with any of its psychiatrists.

Patient's Name

Date of Birth

Patient's Signature

Date

Signature of Parent/Legal Guardian

Relationship to Patient

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your **Notice of Privacy Practices** containing a more complete description of the users and disclosures of my health information. I understand that this organization has the right to change its **Notice of Privacy Practices** from time to time and that I may contact this organization at any time at the address below to obtain a current copy.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

By my signature below I acknowledge receipt of the Notice of Privacy Practices

Patient's Name

Date of Birth

Patient's Signature

Date

Signature of Parent/Legal Guardian

Relationship to Patient

An electronic copy of this form will be retained in your medical record.