Date: _____

Henry F. Crabbe, M.D., Ph.D.

5 SHAW'S COVE, SUITE 207, NEW LONDON, CT
T-(860) 444-8877 • F-(860)444-9660
HENRYCRABBEMD@GMAIL.COM

PATIENT REGISTRATION FORM

DEMOGRAPHIC INFORMATION

Last Name: _____ First Name: _____ MI: _____

Mailing Address (Street): _____ City: _____ State: _____ Zip: _____

Primary Phone _____ Secondary Phone _____

Date of Birth _____ Age: _____ Sex (circle one): Male Female Prefer to not answer

SSN# _____ Marital Status (circle one): Single Married Divorced Widowed

E-Mail Address: _____

Emergency Contact: _____ Relationship: _____ Phone_____

INSURANCE INFORMATION

Primary Insurance Company: _____ Member ID: _____Group #: _____

Name of Policy Holder _____ Relationship to Policy Holder: _____

Policy Holder Date of Birth: _____

Secondary Insurance Company: _____ Member ID: _____Group #: _____

Name of Policy Holder _____ Relationship to Policy Holder: _____

Policy Holder Date of Birth: _____

EMPLOYMENT STATUS

Occupation: _____ Employment Status (circle one): Full-Time / Part-Time / N/A

MEDICAL HISTORY

Personal Medical History (circle all that apply)

Alcoholism/Drug Abuse
Asthma
Diabetes (type: _____)
Emphysema (COPD)
Heart Disease
High Blood Pressure
High Cholesterol
Renal (kidney) Disease
Migraine Headaches
Stroke
Thyroid Disease
Other:

MENTAL HEALTH HISTORY

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

Anxiety Disorders	Obsessive Compulsive Disorder	Other(s):
Bipolar Affective Disorders	Paranoia	
Depression	Post-Traumatic Stress Disorder (PTSD)	
Dissociation/Dissociative Disorders	Psychosis	
Eating Disorders	Schizophrenia	

MEDICATION HISTORY

Current Medications:

Medication Name	Strength	Frequency	Prescribing Physician

Medication Allergies:

_____

_____

_____

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Henry F. Crabbe, M.D., Ph.D., or insurance company to release any information required to process my claims.

In addition, I acknowledge that I have been informed of the Henry F. Crabbe, M.D., Ph.D.'s Notice of Privacy Practices. I understand Henry F. Crabbe, M.D., Ph.D. is a HIPAA compliant office. As a patient, I have the right to obtain a copy of the Notice of Privacy Practices at any time.

Print Patient Name	Patient Signature	Date

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Henry F. Crabbe, M.D., Ph.D.'s Policies

Financial Policy Agreement

Payment for services provided by *Henry F. Crabbe, M.D., Ph.D.* is due at the time that services are rendered. If the patient is covered under insurance, payment of any applicable copayment, co-insurance, or deductible is due at the time of service. If *Henry F. Crabbe, M.D., Ph.D.* is not contracted with the insurance, payment for services is due in full at the time that services are rendered. Insurance will be billed on your behalf, and you will be reimbursed any applicable credits. *Henry F. Crabbe, M.D., Ph.D.* makes every effort to verify your coverage with your insurance. However, you are strongly encouraged to verify your benefits and coverage to ensure you fully understand what is covered. You agree that it is your responsibility to inform the practice of any changes to insurance plan prior to each of your visits, or you may be responsible for the full fee. Some services may not be covered by health insurance. You agree to be fully responsible for payment for all services that are not covered by your health plan. This may include charges for telephone consultations, written correspondence, or reports in connection with a patient's evaluation or treatment, including consultation or correspondence with the patient, family members, past or current treatment providers, educational professionals, attorneys, courts, agencies, or others. If these charges are excluded from your coverage by your health plan, they will be your responsibility. There will be a charge of $50.00, including applicable fees from the financial institution(s) for returned checks or disputed credit card payments. All outstanding balances are expected to be paid within 60 days. Payment plans can be provided upon request.

Appointment Cancellation, No-Show, and Late Arrival Policy

Henry F. Crabbe, M.D., Ph.D.'s policy requires patients to cancel 1 business day in advance of their appointment to avoid a cancellation fee (patients with state Medicaid will not be billed a no-show fee). If their appointment is on a Monday or following a long weekend, the cancellation must be made on the previous business day. Patients are expected to arrive on time for their scheduled appointments. Patients who arrive more than 10 minutes late may not be seen and will be charged a late cancellation fee. *Henry F. Crabbe, M.D., Ph.D.* charges a $50.00 fee for all late cancellations, no-shows, or late arrivals. *Henry F. Crabbe, M.D., Ph.D.* makes every attempt to remain on time for appointments, however, occasionally circumstances arise that may result in an appointment delay.

Discharge Policy

At the discretion of *Henry F. Crabbe, M.D., Ph.D.*, a patient may be discharged from the Practice and their insurance notified if any of the following guidelines are not followed:

- Patient's failure to follow the recommended treatment plan or medical instructions including the Controlled Substance Agreement, if applicable.
- Patient fails to meet financial responsibilities
- The provider cannot provide the level of care necessary to meet the patient's needs
- The member and/or member's family is abusive to the provider and/or staff.
- The patient or provider moves out of the service area.

Confidentiality

Confidentiality is a basis of mental health treatment and is protected by the law. Aside from emergency situations, information can only be released about your care with your written permission. If insurance reimbursement is pursued, insurance companies also often require information about diagnosis, treatment, and other important information in the Disclosure of Health Information as a condition of your insurance coverage. Several exceptions to confidentiality do exist that require disclosure by law:

(1) Danger to self – if there is threat to harm yourself, we are required to seek hospitalization for the client, or to contact family members or others who can help provide protection.

(2) Danger to others – if there is threat of serious bodily harm to others, we are required to take protective actions, which may include notifying the potential victim, notifying the police, or seeking appropriate hospitalization.

(3) Grave disability or impairment – if due to mental illness, you are unable to meet your basic needs, such as clothing, food/water, medical care, and shelter, we may have to disclose information in order to access services to provide for your basic needs

(4) Suspicion of child, elder, or dependent abuse – if there is an indication of abuse to a child, an elderly person, or a disabled person, even if it is about a party other than yourself, we must file a report with the appropriate state agency.

(5) Certain judicial proceedings – if you are involved in judicial proceedings, you have the right to prevent us from providing any information about your treatment. However, in some circumstances in which your emotional condition is an important element, a judge may require testimony through a court order. Although these situations can be rare, we will make every effort to discuss the proceedings accordingly.

Contacting Your Provider

Providers are not immediately available by office telephone, please call the office at 860-444-8877. Calls are generally returned within 2 business days, however, for all prescription refill requests you are required to make an appointment as they are filled in session only. Always leave a phone number where you can be reached along with any updated contact information. As we are an outpatient practice, **we do not service walk ins or provide crisis services**. If your call is an emergency, please call 911 immediately instead of calling the office. Emergency psychiatric services are provided by all hospitals through their emergency rooms and do not require appointments. Emergency room physicians can contact your provider at any time so please provide them with their contact information.

Appointment Confirmations

Henry F. Crabbe, M.D., Ph.D., will attempt to confirm appointments via text upon your consent, however, it is your responsibility to know the date, time, and location of your appointment. *Henry F. Crabbe, M.D., Ph.D.*, has no control in regard to your phone or email connection or reliability. ***Inability or failure to receive a reminder or appointment confirmation via text is not a reason for waiver of fees.***

Communication for Appointment Reminders

Henry F. Crabbe, M.D., Ph.D. may need to use your name, phone number, email address ("Contact Information") to contact you with appointment reminders via phone, text, or email. If this communication is made by text, a text message will be left on your phone. If this communication is made by email, a message will be left at your email address. Messages will contain: Name of Provider: *Henry F. Crabbe, M.D., Ph.D.*, Location of Appointment, Name of Patient, Date & Time of Appointment. You have the right to refuse to give *Henry F. Crabbe, M.D., Ph.D.* your consent to use your telephone number and/or email address for appointment reminders. If you chose to give your consent, you have the right to revoke it, in writing, at any time in the future. Should you agree to communicate via email, telephone or any electronic method of communication, *Henry F. Crabbe, M.D., Ph.D.*, cannot guarantee that those communications will remain confidential. There is a risk that the electronic or telephone communications may be compromised. There is never a 100% guarantee that information will remain confidential when transmitted electronically.

Pharmacy

Henry F. Crabbe, M.D., Ph.D. may have access to your prescription history from other providers through the electronic medical record.

Recording Sessions

Patients are not allowed to record sessions or providers/clinicians under any circumstances.

By signing the ***Consent for Treatment/Acknowledgment Agreement Signature Form***, you agree that you have read, agree with and understand this document, which contains information on *Henry F. Crabbe, M.D., Ph.D.'s* financial policy, professional fees, cancellation/no-show/late arrival, discharge policies, confidentiality, contracting your provider, confirmation and communication for appointment reminders, pharmacy, legal recording sessions, and controlled substances and you agree to abide by its terms during the professional relationship. You also understand and agree that our policies can change at any time.

I have carefully reviewed this document. My signature indicates my full understanding and agreement of this document.

Print Patient Name	**Patient Signature**	**Date**

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Consent for Treatment/Acknowledgment Agreement Signature Form Consent for Treatment

Patients must give voluntary consent for mental health treatment. Your signature (or that of your legal guardian) will demonstrate consent for receiving mental health treatment from *Henry F. Crabbe, M.D., Ph.D.* I voluntarily consent to mental health treatment as performed by the clinicians of *Henry F. Crabbe, M.D., Ph.D.* I understand that mental health treatment may involve certain risks and benefits and I understand these risks and benefits. I also understand the risks and benefits of declining treatment. I am also aware that I have the right to request information about alternative treatment options, should they exist. I have read the above information and I authorize *Henry F. Crabbe, M.D., Ph.D.* to provide mental health services to myself or this patient (if guardian). Acknowledgement of Receipt of Psychiatric Wellness Center's Policies By signing this agreement, you agree that you have read the Psychiatric Wellness Center's Policies and you agree to abide by its terms during our professional relationship. Please look at our website to review our annually updated policy form.

Acknowledgement of Receipt of Notice of Privacy Practices

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement if you wish.

Consent Form for Communication of Protected Health Information

I CONSENT to the communication for appointment reminders via text, email, or phone.

I have carefully reviewed this document. My signature indicates my full understanding and agreement of this document.

Print Patient Name	Patient Signature	Date