HORIZON®
PSYCHIATRY, LLC

839 Bestgate Road
Annapolis, MD 21401
T: 443.889.3312
F: 410.630.8408

NEW PATIENT REGISTRATION FORM

PATIENT INFORMATION (Please Print)

LAST NAME: FIRST NAME: MIDDLE INITIAL: CHECK ONE ☐ MR. ☐ MRS. ☐ MS.

MARITAL STATUS: ☐ SINGLE ☐ MAR ☐ DIV ☐ SEP ☐ WID BIRTH DATE: AGE: SEX: ☐ MALE ☐ FEMALE

STREET ADDRESS: CITY: STATE: ZIP CODE:

HOME PHONE: MOBILE: SSN:

OCCUPATION: EMPLOYER: EMPLOYER PHONE:

OTHER FAMILY MEMBERS SEEN HERE:

FINANCIAL RESPONSIBILITY (Photo ID To The Receptionist)

NAME OF PERSON FINANCIALLY RESPONSIBLE (If Not The Patient) DRIVER'S LICENSE NUMBER/STATE ISSUED:

STREET ADDRESS: CITY: STATE: ZIP CODE:

HOME PHONE: MOBILE PHONE: SSN:

OCCUPATION: EMPLOYER: EMPLOYER PHONE:

INSURANCE INFORMATION (Please Give Your Insurance Card To The Receptionist)

SUBSCRIBER NAME: SSN: BIRTH DATE: INSURANCE CARRIER:

RELATIONSHIP TO SUBSCRIBER: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER GROUP NUMBER: POLICY NUMBER: CO-PAYMENT:

SUBSCRIBER OCCUPATION: EMPLOYER: EMPLOYER PHONE:

STREET ADDRESS: CITY: STATE: ZIP CODE:

HOME PHONE: MOBILE PHONE: EMAIL:

IN CASE OF EMERGENCY (Friend or Relative Not Living At Same Address):

NAME: RELATIONSHIP TO PATIENT:

HOME PHONE: MOBILE PHONE: WORK PHONE:

THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE MY INSURANCE BENEFITS BE PAID DIRECTLY TO THE PHYSICIAN. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE. I HAVE ACKNOWLEDGED RECEIPT OF A COPY OF HP'S "NOTICE OF PRIVACY POLICIES & PRACTICES".

PATIENT/GUARDIAN SIGNATURE DATE

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FINANCIAL AGREEMENT FORM

PATIENT INFORMATION (Please Print)

LAST NAME: FIRST NAME: MIDDLE INITIAL: DATE OF BIRTH:

TYPE: CREDIT CARD NUMBER: EXPIRATION: CVV:

The following information is provided to explain Horizon Psychiatry's payment policy and to avoid any misunderstanding or disagreement concerning payment for professional services. Our policies apply to unaccompanied minors, therefore parents/guardians must plan ahead for prompt payment.

It is the policy of this office that payment in full is expected at the time services are rendered if any of the following circumstances apply:

- You are a self-pay patient. (You have no medical insurance)
- Your therapist is not a participating provider with your insurance/managed care plan.
- You do not wish to have your insurance billed or you have not given us all of the current/correct information required to file an insurance claim.
- Your insurance benefits do not cover the service rendered.
- Your insurance company denied authorization of your therapists recommended testing or treatment plan and you elect to self-pay and proceed with the recommended testing/treatment.

I hereby assume financial responsibility for and agree to make payment in full to Horizon Psychiatry for any and all charges for services received by me and/or any dependents not otherwise authorized or paid by my insurance carrier. Deductibles and/or co-payments are required at the time services are rendered unless payment arrangements are made with a representative of Horizon Psychiatry; prior to the time services are rendered. I certify that the financial information given is true, accurate, and complete to the best of my knowledge, and further authorize, Horizon Psychiatry to investigate any and all financial information given concerning this or related claims. I understand and agree to inform Horizon Psychiatry of changes in my insurance at the time of service so that claims can be filed within the insurance carrier's deadline and I will be responsible for the full fee for services rendered but not covered by my insurance carrier. I further understand that Horizon Psychiatry reserves the right to charge interest and/or pursue delinquent accounts via third party collection agencies or attorneys and that I am responsible for any fees and/or court costs incurred by Horizon Psychiatry during the collections process.

When possible Horizon Psychiatry staff will attempt to contact me to remind me of scheduled appointments 24 -48 hours in advance, this service is provided as a courtesy; however the lack of a confirmation does not alter Horizon Psychiatry's policy. Furthermore, I understand that I will be charged the full fee for all missed appointments. A missed appointment is an appointment not cancelled PRIOR to 24 hours before the scheduled appointment time, or in the case of a Monday appointment, not cancelled by the appointment time of the preceding Friday. If the office is closed you may leave notice on our message system.

I assume financial responsibility for additional services such as phone calls, letter writing, completion of forms and administrative meetings in or out of the office. I understand that claims for these services will be billed at the physicians usual rate, will not be billed to my insurance carrier and remain my obligation to pay.

In the event of a check returned, unpaid from the bank, I acknowledge that a service charge of $35.00 will be incurred for each incidence. In the event that a lawsuit is filed to collect my debt, I expressly waive privileges concerning disclosure of all information necessary to proceed with collection activities and acknowledge that an itemized account history, setting forth services rendered, fees charged and payments received shall be filed as an exhibit.

I agree to notify Horizon Psychiatry of any changes in my billing address or telephone and/or my health insurance carrier information as they occur. This entire authorization is valid for all episodes of care rendered by all providers associated with Horizon Psychiatry. I permit a copy of this authorization and agreement to be used in place of the original.

SIGNATURE OF PATIENT DATE

SIGNATURE OF RESPONSIBLE PARTY (If Not The Patient) DATE

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CONSENT TO TREATMENT FORM

PATIENT INFORMATION (Please Print)

PATIENT LAST NAME:	FIRST NAME:	MIDDLE INITIAL:	DATE OF BIRTH:
GUARDIAN LAST NAME: (If Patient is a Minor)	FIRST NAME:	MIDDLE INITIAL:	DATE OF BIRTH:

I, patient or guardian specified in "PATIENT INFORMATION", voluntarily request treatment from Horizon Psychiatry for patient specified in "PATIENT INFORMATION". I have completed the Patient (Patient Name) Registration forms and reviewed the Privacy and Payment Policies. I fully understand these documents and agree to their terms.

I understand that it is important to discuss with my clinician the nature of treatment, which may include diagnostic formulation, methods, estimated frequency and goals. It is also important to discuss any limits there may be to confidentiality.

I understand that information concerning this case can only be discussed with a third party with my consent unless mandated by law, such as in the risk for physical injury or reporting of abuse. I understand that there may be occasions where it would be helpful or necessary for my treatment provider to speak with other health care professionals within Horizon Psychiatry about my case and I authorize such communications unless I specifically request that information not be shared. If information is to be shared with other professionals outside of Horizon Psychiatry I will need to authorize such communications with a written Release of Information.

I further understand that behavioral health treatment offers no guarantee with regard to improvement of my condition. I am aware that I may withdraw from treatment at any time but if I decide to terminate treatment, I understand that it is important to discuss that with my provider first.

I certify that I have read the above Consent to Treatment and that I fully understand and agree with its terms.

SIGNATURE OF PATIENT DATE

SIGNATURE OF GUARDIAN (If Patient is a Minor) DATE

We strongly believe that a good therapist/patient relationship is based upon understanding and open communication. We have instructed our staff to make every effort to clarify any question or misunderstanding you have concerning your account. We hope to avoid any disagreement over payments for professional services. Financial Agreement