

# Russell Denea, MD, LLC Psychiatry and Psychoanalysis

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[DrDenea.com](http://DrDenea.com)

**PATIENT INFORMATION**

DATE: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Sex:  Male  Female

Date of Birth: \_\_\_\_\_ Marital Status:  S  M  D  Sep.  W SS#: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State /Zip: \_\_\_\_\_

Phone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ (OK to call:  Y  N) Cell: \_\_\_\_\_

Email: \_\_\_\_\_ Preferred Contact: H W Cell Email

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

In the event of an **EMERGENCY** you may **CONTACT:** \_\_\_\_\_ at \_\_\_\_\_  
Name and Relationship to Patient Phone\_

**DOCTOR/THERAPIST INFORMATION**

Physician Name (your regular doctor): \_\_\_\_\_ Phone: \_\_\_\_\_

Physician Address: \_\_\_\_\_ City: \_\_\_\_\_ State /Zip: \_\_\_\_\_

Therapist Name: \_\_\_\_\_  CSW  Ph.D.  Other: \_\_\_\_\_ Phone: \_\_\_\_\_

Therapist Address: \_\_\_\_\_ City: \_\_\_\_\_ State/Zip: \_\_\_\_\_

**INSURANCE INFORMATION**

**Method of Payment:**  Cash  Insurance

**COMPLETE ONLY IF WE ARE TO BILL INSURANCE. MISSING OR INACCURATE INFORMATION WILL DELAY OR PREVENT INSURANCE PAYMENT !!**

<b><u>PRIMARY INSURANCE COMPANY:</u></b>		<b><u>SECONDARY INSURANCE COMPANY:</u></b>	
Claims Phone		Claims Phone	
Claims Address		Claims Address	
ID NUMBER		ID NUMBER	
GROUP NUMBER		GROUP NUMBER	
COPAY	AUTHORIZATION #	COPAY	AUTHORIZATION #
POLICYHOLDER NAME (IF NOT SELF)		POLICYHOLDER NAME (IF NOT SELF)	
RELATIONSHIP: SPOUSE ___ CHILD ___ OTHER ___		RELATIONSHIP: SPOUSE ___ CHILD ___ OTHER ___	
POLICYHOLDER SOCIAL SECURITY NO		POLICYHOLDER SOCIAL SECURITY NO	
POLICYHOLDER DATE OF BIRTH:		POLICYHOLDER DATE OF BIRTH:	
POLICYHOLDER ADDRESS IF DIFFERENT:		POLICYHOLDER ADDRESS IF DIFFERENT:	

## AUTHORIZATIONS

**Unsigned authorizations will prevent us from providing treatment and/or prevent us from contacting your insurance company for payment.**

➤ **Treatment Authorization**

I authorize **Russell Denea, M.D.** to perform any therapy procedures that are deemed necessary for me in his office. I understand the risk associated with any medical procedure that is performed. I also agree that this authorization will cover all medical services rendered until such authorization is revoked by me.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(patient or parent/guardian if patient is under 18)

➤ **Insurance Authorization**

I authorize release of any information necessary to process my insurance claim, assign payment directly to **Russell Denea, MD, LLC**, and acknowledge that I am financially responsible for any unpaid balance.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(patient or parent/guardian if patient is under 18)

➤ **Medicare**

I request that payment of Medicare benefits be made to **Russell Denea, MD, LLC** for services provided me by Dr. Denea. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits or the benefits payable for related service.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

➤ **Privacy** I acknowledge that I have received a copy of the privacy practices from Russell Denea, MD, LLC

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

➤ **Permissions**

List all people with whom we may discuss your billing or health information: \_\_\_\_\_

➤ **OFFICE POLICIES**

1. **Confidentiality** - All information between psychiatrist and patient is held strictly confidential unless:

- The patient authorizes release of information with his/her signature.
- The patient presents a physical danger to himself or herself.
- The patient presents a danger to others.
- Child/elder abuse or neglect are suspected.

In the latter two cases, we are required by law to inform potential victims and legal authorities so that protective measures can be taken.

2. There may be a charge for time involved in lengthy telephone discussions.

3. It is YOUR RESPONSIBILITY to obtain an authorization from your insurance company, if required. Many insurance companies REQUIRE THE PATIENT to contact them for authorization. If you need assistance we would be happy to help you, but this may generate increased fees for the time spent by our staff working with an insurance company with which we do not participate.

4. **Cancellation/Missed Appointment Policy** Our office policy requires **24 hours notice if you are unable to keep a scheduled appointment. You will be billed** for missed appointments at a rate of ½ the usual visit fee, and these charges are not reimbursable by insurance.

5. It is the patient's responsibility to inform this office of any change in medical status including medications (prescribed and over the counter), insurance, address, and/or telephone number.

***I have read, understand, and agree to the above office policies.***

Signature: \_\_\_\_\_ Date: \_\_\_\_\_