Russell Denea, MD, LLC
Psychiatry and Psychoanalysis
4102 A1A South
Saint Augustine, FL 32080
Telephone: 904-471-1300
Fax: 904-471-1333
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 !!

PRIMARY INSURANCE COMPANY:		**SECONDARY INSURANCE COMPANY:**	
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:**	

-OVER-

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 (or viewed online) 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: ___________________________