Premier
PSYCHIATRIC SERVICES

Patient Information

Patient's Last Name First Middle Initial		Date of Birth	Sex Male Female	Gender Male Female
Home Address	City	State	Zip Code	Home Phone
Mailing Address (if different from above)	City	State	Zip Code	Cell Phone
Status (please circle most recent) Married Partnered Divorced Single Widowed Legally Separated		Social Security Number	Driver's License Number	Date of Expiration
Employer		Occupation		Employer's Phone
Employer's Address	City	State	Zip Code	
Last Name of Spouse, Partner or Legal Guardian First Name		Date of Birth / /	Phone	
Home Address City State Zip Code		Preferred Pharmacy	City	Pharmacy Phone
Primary Care Physician, City	Office Phone ( )	Referring Physician / Therapist, City		Office Phone

How did you hear about our office?
Referral from a medical professional or therapist: _____ Insurance: _____

Friend or Family: _____ Website / Facebook: _____ Other: _____

CONSENT FOR TREATMENT, BILLING AND RELEASE OF MEDICAL INFORMATION

I understand I am responsible for all charges incurred for professional medical/mental health services provided for me or my dependent, regardless of insurance coverage. I authorize direct payment of any benefits to Premier Psychiatric Services, Inc. from my insurance company, health plan, third-party payer or any intermediaries.

I authorize Premier Psychiatric Services, Inc. and Mitchell Galerkin, M.D., to release medical records and/or information to representatives of my insurance company/health plan/third-party payer or any intermediary for the purpose of processing my medical/mental health claims or obtaining benefits. In addition, I authorize Premier Psychiatric Services, Inc. and Mitchell Galerkin, M.D., Inc. to release medical information to other providers for the purpose of specialist referrals and/or other continuing care.

- **I consent to treatment by Premier Psychiatric Services, Inc. for counseling, psychotherapy and/or psychiatric medical care as deemed advisable and/or necessary by the professional staff of Premier Psychiatric Services, Inc.**
- **I also consent to release my medication history from my insurance company or pharmacy benefits manager to Premier Psychiatric Services, Inc.**

Patient Name and Signature **Date**

INSURANCE INFORMATION

Subscriber's Last Name First Middle Initial	Date of Birth	Subscriber ID / Subscriber Social Security Number
Primary Insurance Company's Name		Insurance Company Phone

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Adult Personal History

*** All paper documents will be loaded into chart and then shredded.**

Patient's Name: _____ **DOB:** _____ **Date**: _____

Person completing form for patient:_____
Please take your time and complete entire form. The information will help your health care provider understand you better. Use the back of the last sheet of this form if necessary. Call 911 if you are having a medical emergency.

Reason for seeking help:_____
_____
_____
_____

CIRCLE or CHECK any of the following that apply to you now or within the past month (feel free to explain):

Depression
Crying spells
Hopelessness
Relationship breakup
Loneliness
Emptiness
Loss of appetite
Sleep disturbance
Nightmares
Thoughts of harming self
Thoughts of harming others
Suicide attempts/injuries
Hearing voices
Seeing things others don't
Unusual thoughts

Increased alcohol use
Increased drug usage
Blackouts/memory loss
Withdrawal symptoms
Financial Worries
Loss of control in:
- alcohol/drug use
- overeating/binging
- purging
- yelling/breaking
- hitting people
- endangering self
- endangering others
- spending

Nervous/Anxious
Panic attacks
Can't concentrate
Confusion
Mood swings
Racing thoughts
Fear of dying
Job stress
Decreased activity
Not seeing friends
Feel controlled
Feel talked about
Guilt/shame
Sexual problems
School problems

Are you currently seeing a therapist? (YES / NO) Name_____
Phone_____Address_____
Beginning date_____frequency_____

Have you seen a therapist in the past? (Yes / NO) Name_____
Beginning date_____Ending Date_____Frequency_____

Past Metal Health Hospitalizations, Intensive outpatient treatment, or chemical dependency treatment:

Name of facility	Approximate date	Duration

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Patient's Name: _____

Physical Health: _____

Circle the number for each item that applied to you in the past or now:

1. Allergies
2. Asthma
3. Ulcers
4. Cancer
5. Stomach problems
6. Pancreatitis
7. Chronic pain
8. Heart disease
9. Bacterial endocarditis
10. Seizures
11. High blood pressure
12. Low blood pressure
13. Diabetes
14. Hypoglycemia (low blood sugar
15. Thyroid Problems
16. Liver disease
17. Vision problems
18. Hearing problems
19. Speech problems
20. Dental problems
21. Weight loss
22. Weight gain
23. Severe headaches/migraines
24. Frequent neck/shoulder pain
25. Head injuries
26. Physical Abuse
27. Sexual abuse
28. Premenstrual syndrome
29. Sexually transmitted diseases
30. Positive HIV
31. AIDS
32. Tuberculosis
33. Hepatitis
34. Major surgeries
35. Chronic fatigue syndrome
36. Impotence
37. Prolapsed mitral valve
38. Circulation problems
39. High Cholesterol
40. Irritable bowel
41. Broken bones
42. Accidents
43. _____
44. _____

List all psychiatric medications in the past that **did not work** for you:

Medication	Dosage	Directions	Reason for taking

Please list any surgeries you have had: _____

_____

Allergies (list all): _____

Tobacco Use: **Yes / No** How much: _____

Caffeine Use: **Yes / No** How much: _____

Advance Directive: **Yes / No**

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Patient Name:_____

Flu shot Yes / No Approximate Date _____ Location Administered_____

Pneumococcal vaccine Yes / No Approximate Date _____ Location Administered_____

List of Current Medications:

Medication	Dosage	Directions	Reason for taking

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Patient's Contact Information Sheet

1. **In case of an emergency I authorize Premier Psychiatric Services, Inc. to contact:**
   _____ at (_____)_____ - _____ relationship:_____.
2. I wish to be contacted in the following manner (please check all areas that apply for you):
   - ☐ **Home telephone**: (_____)_____-_____
   - ☐ **Mobile:** (_____)_____-_____.
     - ☐ I would like to receive appointment reminders by text to my mobile phone.
   - ☐ **Work phone:** (_____)_____-_____
3. **Email** me information such as appointment reminders:

   Email address: _____ @ _____

Specific Release of Information

In addition to office policy and Protected Health Information, you may choose to give specific people access to your PHI. Please list below (examples would be physicians, therapists, family members, friends). You may make changes to this list at any time by contacting the receptionist and notifying in writing.

1) I Hereby give permission to Premier Psychiatric Services, Inc, to release medical information to:
   _____relationship:_____Phone:_____
   Address:_____
   Fax:_____

2) I Hereby give permission to Premier Psychiatric Services, Inc, to release medical information to:
   _____relationship:_____Phone:_____
   Address:_____
   Fax:_____

3) I Hereby give permission to Premier Psychiatric Services, Inc, to release medical information to:
   _____relationship:_____Phone:_____
   Address:_____
   Fax:_____

4) I Hereby give permission to Premier Psychiatric Services, Inc, to release medical information to:
   _____relationship:_____
   Phone:_____
   Address:_____
   Fax:_____

_____ _____

Patient's Name (Please Print) / Signature of Patient, or Legal Guardian **Date**

DOB:_____

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Office Policies

Welcome to Premier Psychiatric Services. The office policies, below, may be changed by Premier Psychiatric Services with 30 days written notice.

Medication Refills

Please request medication refills by having your pharmacy send an electronic request or via our Patient Portal (see page 2 of Office Policies). Faxes from pharmacies are not accepted. Please notify your pharmacy of this policy. Please allow at least three working days for refill requests to be processed. Your provider prescribes enough medication to get you to your next scheduled appointment made at the time of previous appointment. If you reschedule your appointment or miss an appointment and need additional medication, you will be charged a $15.00 refill fee. Scheduled medications will not be refilled without being seen at an appointment.

Billing and Payments

Co-payments and fee-for-service payments for office visits are due at the time of your visit. The amount of your co-payment or co-insurance is determined by your health plan or insurance coverage. Payment for non-covered services are due at the time you receive the service.

Premier Psychiatric Services, Inc. is not a Medicare Participating Provider at this time. Neither you nor Premier Psychiatric Services, Inc. bill or receive reimbursement from Medicare or any Medicare product. Our fee for service is not limited to Medicare rates. Your appointment fee is due at the time of the service.

If you have private insurance that we contract with, our office will bill your insurance company for you. Our office accepts assignment of benefits; however, you are responsible at the time of the visit, for any deductibles, co-insurance amounts, and charges not paid by your insurance. We do our best to verify your health plan or insurance coverage and limitations, but you are responsible for keeping us up to date on any changes to your policy.

There will be a charge of $30.00 for each returned check. Premier Psychiatric Services, Inc. reserves the right to request payment by cash, credit card or debit card from any patient with two or more returned checks in any 12-month period.

Patients with unpaid personal balances cannot schedule an appointment until the balance has been paid in full or an agreed upon payment arrangement has been made and kept with the billing manager.

Please inform the receptionist of any change to your name, address, telephone number, or your employment. This can be done at the office, over the phone or via our Patient Portal. Please discuss any questions or special circumstances with our receptionist.

Refunds for credits on your account will be made to you or your health plan or insurance company, by check, to the address we have on file. Refunds may take up to four weeks to process. Please contact our office to inquire about any potential credit or balance on your account at (916) 294-7062, Ext. 2.

Patient's Name and Signature:_____

Date: _____

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Office Policies Continued

Forms Completion
Premier Psychiatric Services, Inc. charges a minimum fee of $50.00 for completing letters and forms including disability paperwork and medication prior authorizations required by your insurance. Forms will not be completed without your verbal authorization. Our office does not complete forms for health examinations, school or sports physicals or similar examinations.

Missed Appointments
Premier Psychiatric Services, Inc. will attempt to contact you by email or text 3 days in advance to notify you of your appointment.

You must cancel at least 24 hours prior to your appointment to avoid a late cancellation fee. If you miss a scheduled diagnostic appointment or do not give a 24-hour cancellation notice prior to a scheduled diagnostic appointment, you will be charged a fee of $260.00. If you miss a scheduled follow-up appointment or do not give a 24-hour cancellation notice prior to a follow-up appointment, you will be charged a fee of $145.00. The fee will be charged to your credit card on file immediately after the missed appointment or the late cancellation. This policy is regardless of reason or emergency.

Late Arrivals
If you arrive more than 10 minutes after your appointment time, you may be rescheduled for a different time and date, and you will be charged a missed appointment fee.

Notice of Privacy Practice and Patients' Rights and Responsibilities Acknowledgment
I acknowledge that I have received and understand the Premier Psychiatric Services, Inc. Notice of Privacy Practices, and the Patient's Rights and Responsibilities Policy.

Utilizing our phone services for clinical questions
If you have an urgent (non-emergency) clinical question you may call and leave a message for the provider directly at our office (916) 294-7062, Ext. 4. This call may cost a $25.00 charge. Please do not use this line if you have a medical/mental health emergency or may potentially harm yourself or others. Please contact 911 immediately in those circumstances. The provider will contact you within 24 hours if your provider deems your call an urgent clinical question. If the provider deems your question not an urgent clinical question, a staff member will contact you within 48 business hours.

You may also contact our clinical staff members at (916) 294-7062, Ext. 3 at no cost. This line is for questions regarding paperwork such as disability or prior authorizations, or questions about medication refills. Please allows 72 hours for us to return your call, and please allow 5 business days to complete paperwork.

Restrictions
Premier Psychiatric Services is in close proximity to a school and shares a building office with a child therapist. If you have any legal restrictions from being around children or a school, you will not be able to be a patient at our practice.

Patient's Name:_____

Patient's or Legal Guardian's Signature: _____ **Date**: _____

Policy Last Updated: 05/08/2019

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Credit Card Authorization Form

Patient's Name:_____

Card Holder's Name:_____

Card Number:_____

Exp. Date:_____ CV Code:_____ Zip code of Card Holder:_____

Card Type:

Visa:_____ American Ex.:_____ Master Card:_____ Discover:_____ Debit Card:_____

- I authorize Premier Psychiatric Services, Inc. to bill the credit/debit card listed above if the patient's balance is not paid at the time of the appointment or when there is an outstanding balance.
- I plan to pay the bill via check/cash/or credit card at the time of the appointment. If I do not provide the payment at the time of the appointment, I authorize Premier Psychiatric Services, Inc. to automatically charge my credit card whenever I have an outstanding balance. Our office will do our best to contact the patient by phone before the card listed above is charged.
- If there is an unpaid balance, then you will need to pay the balance before rescheduling your next appointment. Please contact the billing manager if you have any questions at (916) 294-7062, Ext. 2.
- I understand that next appointment will not be scheduled until the patient's balance is paid in full or payment arrangement has been made and kept as agreed upon between the patient and the office biller.

By signing below, I have read this form in its entirety, agree and understand the policy.

Please note: If your balance remains unpaid for more than 90 days, the amount due will be sent to Bridgeport Collections, (408) 295-7087. Premier Psychiatric Services, Inc. will do its best give the patient referrals to find another provider and will encourage you to put yourself under a provider's care as soon as possible.

Patient's Signature: _____ **Date:** _____

Card Holder's Signature: _____**Date:** _____

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Noridian- Medicare Private Contract / Opt- Out of Medicare Notice

Section 4507 of the 1997 Balanced Budget Act allows a physician or practitioner to enter a private contract with a Medicare beneficiary.

I, Mitchell Galerkin M.D, have not been excluded from the Medicare 1128, 1156, or 1892 of the Social Security Act 1467440339; however, I have opted out of Medicare and all Medicare products. I am able to see Medicare patients as fee for service and am not limited by Medicare rates.

I, the Medicare beneficiary, or my legal representative understand that Medicare limits do not apply to what Mitchell Galerkin M.D. may charge for items or services furnished.

I, the Medicare beneficiary, or my legal representative accept full responsibility for payment of charges for all services furnished by Mitchell Galerkin M.D.

I, the Medicare beneficiary, or my legal representative agree not to submit a claim to Medicare or to ask Mitchell Galerkin M.D. to submit a claim to Medicare.

I, the Medicare beneficiary, or my legal representative understand that Medicare payment will not be made for any items or services furnished by Mitchell Galerkin M.D. that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted.

I, the Medicare beneficiary, or my legal representative enter into this contract with the knowledge that I have the right to obtain Medicare-covered items and services from a physician and/or practitioner who has not opted out of Medicare, and I am not compelled to enter into private contracts that apply to who has not opted out of Medicare and I am not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted out of Medicare.
The expected or known effective date and expected or known expiration date of the opt-out period is 9/14/2017 (effective date) and 9/14/2019 (expiration date).

I, the Medicare beneficiary, or my legal representative understand that Med-gap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.

This contract cannot be entered into by me, the Medicare beneficiary, or by my legal representative during a time when I, the Medicare beneficiary, requires emergency care services or urgent care services. (However, a physician may furnish emergency or urgent care services to a Medicare beneficiary in accordance with 3044.28 of the Medicare Carriers Manual.)

I, Mitchell Galerkin M.D., will supply CMS a copy of this contract upon request. Provider NPI: 1467440339

Patient's Signature or Legal Representative:_____ Date: _____

Patient's Name or Legal Representative: _____

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Patients' Rights and Responsibilities Policy

1. Be treated with dignity and respect.
2. Treat staff and providers with dignity and respect.
3. Be treated fairly, regardless of their race, religion, gender, ethnicity, age, disability, or source of payment.
4. Have treatment and other member information kept confidential. Only where permitted by law may records be released without the member's permission as described in the office Protected Health Information disclosure.
5. Know about treatment choices. This is regardless of cost or coverage by their benefit plan.
6. Share in developing their plan of care.
7. Receive a clear explanation of their condition and their treatment options.
8. Receive information about clinical guidelines used in providing and managing their care.
9. Ask their provider about their work history and training.
10. Give input on the Patients' Rights and Responsibilities Policy.
11. Know about advocacy and community groups and prevention services.
12. If asked, your insurance company may act on the member's behalf as an advocate.
13. Freely file a complaint or appeal, and learn how to do so.
14. Know of their rights and responsibilities in the treatment process.
15. Request certain preferences in a provider from your insurance company.
16. Receive a copy of HIPAA Disclosures. I have received, read and understand this disclosure.
17. Receive information about the benefits, risks and side effects of all prescribed medications. Patients can ask to have such information reviewed at any time.
18. Follow agreed upon office policy and mutually agreed upon treatment plan.
19. To show up for scheduled appointments so the provider can affectively help you to meet your treatment goals. Refills may be denied if the provider cannot perform a clinical evaluation.
20. To take medications as prescribed without making changes to the treatment regimen without the provider's consent.
21. To keep medications safe from theft and loss, and to not let others use your medication(s). The provider may choose not to refill your medication(s) early for any reason.

If you have any questions about your rights and responsibilities, please contact our office at (916) 294-7062, Ext. 1

Patient's or Legal Guardian's Name:_____

Patient's or Legal Guardian's Signature:_____ Date:_____