Primary Care Physician Name/#
_____

DrJohnCantwell.com

Cantwell Family Psychiatry, LLC

770 Middle Street, Fairhope, AL 36532
Mon – Thurs | 8am – 5pm | 251-517-5800

Adult Registration Form

Please print and accurately complete every blank on this form.

Reason for appointment _____
_____
Patient Name _____
Last First Middle

Date of Birth ___ /___/____ Age ____ Male ___ Female ___ Social Security Number _____
Home Phone _____ Cell _____ Cell Company _____ Work _____
When we contact you, may we leave a voicemail? ___ yes ___ no May we leave a text message? ___ yes ___ no
Email Address _____ (For appointment reminders only)
Home Address _____ City _____ State _____ Zip_____
Employer _____ Full-time/Part-time (Circle) Marital Status M/S/D/W (Circle)
Emergency Contact Name _____ Relationship _____ Phone _____
Referred by (Name and Number) _____
Pharmacy (Name/Number/Location)_____

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Primary Insurance Co _____Secondary Insurance Co _____
Phone Number _____ Phone Number _____
Policy Number _____Policy Number _____
Group Number _____Group Number _____
Policyholder's Name _____ Policyholder's Name _____
Policyholder's Date of Birth _____ Policyholder's Date of Birth _____
Policyholder's Social Security _____ Policyholder's Social Security _____
Relationship to Patient ___Spouse ___Child ___Other Relationship to Patient ___Spouse ___Child ___Other
Co-Pay Amount _____ Co-Pay Amount _____

Medications

Please bring **all medication bottles** (prescription and OTC) you currently take to your first appointment.

Consent for Medical Treatment

I voluntarily consent to outpatient treatment provided by John Cantwell, M.D. and his associates at Cantwell Family Psychiatry, LLC (CFP). I consent to testing for drugs and alcohol, if deemed advisable. I am aware that the practice of medicine is not an exact science and that no guarantees have been made as to the result of treatments or examinations. I authorize CFP to render to me all customary care, therapy, treatment, tests, and procedures considered advisable.

Insurance Pre-Authorization

I understand that I am responsible to notify my insurance company and obtain prior authorization, if necessary, before CFP provides treatment.

No Show and Cancellation of Appointments

CFP requires 24 hours notice during the business week (Mon–Fri) if you wish to cancel an appointment. Appointments missed or cancelled with less than the 24-hour notice are subject to a $50.00 non-refundable fee, plus 3% if paid by credit card. Insurance companies do not pay for no-shows or cancelled appointments. I understand that no future appointments will be scheduled until I pay the cancellation fee.

_____ _____ _____
Signature of Patient Print Name Date

Patient Name _____ Date of Birth _____

Assignment of Benefits

I assign all payments of authorized Medicare, any insurance, and/or third party plan benefits assigned to me, or on my behalf, for CFP services, to be paid directly to CFP.

Release of Information for Payment

I authorize any holder of medical information about me to release to Medicare, and/or other health insurance or third party plan and their respective agents any information needed to determine these benefits for related treatment. I agree to the release of medical or other information about me to government regulatory agencies (federal or state) by telephone, by facsimile, by e-mail, or in writing, as required by law. I understand that I am releasing CFP, its agents, and employees from all liability that may arise from the release of such information.

Telephone /Email Consent

I authorize CFP and its agents to communicate with me about appointments, prescriptions, and account charges by calling and/or leaving a message at any phone number I have provided, including home, cell and work phones. CFP does not communicate through email with its patients, except for appointment reminders.

Financial Responsibility Agreement

I agree that I will provide accurate and complete medical information to CFP, including all insurance changes that may affect my behavioral health benefits. My failure to do so may result in non-payment of benefits to CFP, for which I agree to assume personal financial responsibility.

Cash, check, and debit cards are accepted; credit cards are accepted with a 3% convenience fee. The returned check fee is $35 per check; and henceforth, CFP will no longer accept checks as payment from you.

If you request copies of any part of your medical record, Alabama law regulates the copying charges: $1 per page for the first 25 pages and $0.50 for each additional page. A search fee of $5, mailing costs, and copy charges are payable in advance. There is also a fee associated with reports, forms, and letters. Phone calls outside of normal CFP business hours will also incur a charge, depending on duration, at a rate of $25 per intervals of 5 minutes.

Dr. Cantwell is an in-network provider with Aetna, Blue Cross Blue Shield, Cigna, Medicare, and United Health Care/United Behavioral Health/OPTUM. If these insurance providers require a co-payment, co-insurance, or if my deductible has not been met, I understand that I am responsible for these charges at the time of the appointment.

If a delinquent account is referred to an attorney and/or collection agency, the patient agrees to pay reasonable costs of collection, including attorney and collection agency fees. No further appointments will be scheduled.

Prescription Renewals/Refills

No prescriptions will be filled or renewed after normal business hours, Mondays – Thursdays, 8am to 5pm. If you need to fill your prescription prior to your next appointment, CFP requires 3 business days (72 hours) to renew prescriptions. Prescriptions will not be filled after hours, weekends, or holidays.

Acknowledgement of Receipt of Privacy Practices

I acknowledge that I was offered a copy of CFP's Notice of Privacy Practices. If I would like to receive a paper copy at any time, I may request one from Dr. Cantwell's office by calling 251-517-5800.

_____ _____ _____

Signature of Patient Print Name Date