DrJohnCantwell.com

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

Primary Care Physician Name/#
_____

Child & Adolescent Registration Form

Please print and accurately complete every blank on this form.

Reason for appointment _____
_____

Child's Name_____
Last First Middle
Date of Birth ___ /___/____ Age ____ Male ___ Female ___ Child's 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_____
Emergency Contact Name _____ Relationship _____ Phone _____
Referred by (Name and Number) _____
Pharmacy (Name/Number/Location) _____

1st Parent/Legal Guardian Name _____
Address (if different) _____
Date of Birth ___ /___/___ Age _____ Social Security Number _____

2nd Parent/Legal Guardian Name _____
Address (if different) _____
Date of Birth ___ /___/___ Age _____ Social Security Number _____

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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: Mother ___ Father ___Other ___ Relationship to Patient: Mother ___ Father ___ Other ____
Co-Pay Amount _____ Co-Pay Amount _____

Medications

Please bring all medications bottles (prescription & OTC) your child currently takes to their first appointment.

Consent for Medical Treatment

I voluntarily consent for my child to receive outpatient treatment provided by John Cantwell, M.D. and his associates at Cantwell Family Psychiatry, PC (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 my child 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. If not obtained, I understand that I will be required to self-pay for services.

Legal Authority

I have legal authority to make medical decisions for the above-named child. (Please sign below)

Assignment of Benefits

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

_____ _____ _____ _____
Signature of Parent/Guardian Print Name Relationship Date

Patient Name _____ Date of Birth _____

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 no show or cancellation fee.

Release of Information for Payment

I authorize any holder of medical information about my child 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 my child to government regulatory agencies (federal or state) by telephone, by facsimile, by e-mail, or in writing, if 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.

Consent To Contact Patient On Cell Phones

Express prior consent to contact patient by cell phone: You agree, in order for us to service your account or to collect monies you may owe, Cantwell Family Psychiatry, PC and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing devices, as applicable. I/We have read this disclosure and agree that Cantwell Family Psychiatry, PC its employees and/or agents may contact me/us as described above.

Financial Responsibility Agreement

I agree that I will provide accurate and complete medical information to CFP, including all insurance changes that may affect my child's 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. I am responsible for this child's financial account. 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 thereafter, CFP will no longer accept checks as payment from you. If you request copies of any part of your child's 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 with Dr. Cantwell will also incur a charge, depending on duration, at a rate of $30 per interval of 5 minutes. Dr. Cantwell is an in-network provider with Aetna, Cigna, United Health Care/United Behavioral Health/Optum, and Medicare. If these insurance providers require a co-payment, co-insurance, or if my child's deductible has not been met, I understand that I am responsible for these charges at the time of the appointment.

Adding Collection Fees To Account Balances

Agreement to Pay: I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay this fee, including any/all collection agency fees, (33.33%), attorney fees and/or court costs, if such be necessary. I waive my right to claim exemption under the laws of the Constitution of the State of Alabama and any other State. 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.

Child and Adolescent Custody

If biological parents are divorced, or if patient is adopted or in foster care, I have given CFP the necessary legal documents regarding the child or adolescent patient's legal custody. Custody changes will be updated immediately.

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 Parent/Guardian	Print Name	Relationship	Date