Albuquerque Psychiatry & Psychology, LLC

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- ☐ Barry Schooley, MSN, APRN, FNP-C

☐ NP ☐ PT Update

Patient Information

Patient Name:	Phone # for CONFIDENTIAL message:
Street Address:	Cell Phone:
City: State: Zip:	Work Phone:
Gender: ___Male __ Female	Other Phone:
Date of Birth: Soc Security #	Email:

Referred by: ___Single ___Married ___Partner ___Divorced ___Separated ___Widowed ___Child

Responsible Billing Party *(if different than above)*

Guarantor's Name	Home Phone:
Street Address:	Cell Phone:
City: State: Zip:	Work Phone:
Gender: ___Male __ Female	Employer:
Date of Birth: Soc Security #	Relationship to Patient: ___parent ___guardian
Email:	___spouse ___partner ___other

Additional Responsible Billing Party

Guarantor's Name	Home Phone:
Street Address:	Cell Phone:
City: State: Zip:	Work Phone:
Gender: ___Male __ Female	Employer:
Date of Birth: Soc Security #	Relationship to Patient: ___parent ___guardian
Email:	___spouse ___partner ___other

Primary Care Provider Release

☐ **I DO** give my permission to the therapist listed above to communicate with my Primary Care Provider regarding my treatment.

☐ **I DO NOT** give my permission to the therapist listed above to communicate with my Primary Care Provider

☐ **I DO NOT have a** Primary Care Provider

Primary Care Provider: Phone # Fax #

Signature of Patient 14 years or older **Signature of Parent/Guardian for patient under 18**

Emergency Contact Information

Emergency Contact Name:	Home Phone
Relationship to Patient:	Cell Phone
___parent ___guardian ___spouse ___partner ___other _______________	Work Phone
Emergency Contact Name:	Home Phone
Relationship to Patient:	Cell Phone
___parent ___guardian ___spouse ___partner ___other _______________	Work Phone

Signature of the guarantor **print name** date

Signature of patient 14 years or older, if different than the above **print name** date

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☐ **Primary Insurance**	
Primary Insurance Co:	Member ID
Phone#	Group #
Policy Holder's Name	Employer
Relationship to Patient: ____self ___parent ___guardian ___spouse ___partner ___other	
Policy Holder's Date of Birth	Social Security #

☐ **Secondary Insurance**	
Secondary Insurance Co:	Member ID
Phone#	Group #
Policy Holder's Name	Employer
Relationship to Patient: ____self ___parent ___guardian ___spouse ___partner ___other	
Policy Holder's Date of Birth	Social Security #

☐ **Private Pay Client Agreement** *(not using insurance)*		
Initial Session	$	Other/Comments
up to 60 minutes	$	
up to 45 minutes	$	
up to 30 minutes	$	
Beyond 60 minutes	$	

Please review the following and sign in the space provided:

- I authorize the release of medical or other information necessary to process my medical claims.
- I understand that my provider may contact my primary physician to obtain/exchange information about my continuity of care. Should my provider want to speak with other health care professionals with knowledge of me, I will be asked to sign a release of information before they are contacted.
- I authorize payment of medical benefits to my therapist;
- It is my responsibility to know and understand the benefits of my insurance policy;
- It is my responsibility for services/balances not covered by my insurance;
- In the event of an overpayment, your provider will reimburse the authorized party;
- It is my responsibility to notify APP of my current address, phone numbers, and email.
- I am aware that emails and or text messages with my provider are not privacy protected
- It is my responsibility to keep appointment times or cancel no later than 12 noon one business day before my appointment; I understand that I can be charged up to $75 for appointments I do not cancel on time.
- I understand office policy to turn unpaid accounts past 60 days to a collection agency.

Signature of the guarantor | **print name** | date

Signature of patient 14 years or older, if different than the above | **print name** | date