

~SPA~

Salem Psychiatric Associates PC
821 Saginaw St S
Salem, Or. 97302

Registration, Consent to Treatment, and Fee Agreement

Patient Information

LAST NAME: _____ FIRST NAME: _____ MIDDLE INITIAL: _____

MAIDEN OR OTHER NAMES USED: _____ GENDER _____

DOB (MM/DD/YYYY): ____/____/____ SSN: ____-____-____ DRIVERS LICENSE _____

State

STREET ADDRESS: _____ APARTMENT # _____

CITY _____ STATE _____ ZIP _____

MAILING ADDRESS (IF DIFFERENT THAN ABOVE): _____

CITY _____ STATE _____ ZIP _____

HOME PHONE: (____)-____-____ MESSAGE OK? YES NO CELL PHONE: (____) _____ - _____

PLACE OF EMPLOYMENT or SCHOOL ATTENDING: _____

WORK TELEPHONE NUMBER: (____)-____-____ MESSAGE OK? YES NO

EMERGENCY CONTACT: _____ PHONE: _____

PRIMARY CARE PHYSICIAN: _____ PHONE: _____

Insurance Information

PRIMARY INSURANCE: _____

ADDRESS: _____ PHONE: _____

EMPLOYER: _____

SUBSCRIBER/MEMBER NAME: _____ DOB: _____

SUBSCRIBER ID # _____ GROUP/POLICY # _____

RELATIONSHIP TO PATIENT/CLIENT: _____

SECONDARY INSURANCE: _____

ADDRESS: _____ PHONE: _____

EMPLOYER: _____

SUBSCRIBER/MEMBER NAME: _____ DOB: _____

SUBSCRIBER ID # _____ GROUP/POLICY # _____

RELATIONSHIP TO PATIENT/CLIENT: _____

PLEASE, YOU MUST READ AND SIGN THE OTHER SIDE OF THIS FORM

COMPLETE FOR ADULT RESPONSIBLE FOR PAYMENT OF CHARGES NOT COVERED BY INSURANCE

LAST NAME: _____ FIRST NAME: _____ MIDDLE INITIAL: _____

MAIDEN OR OTHER NAME YOU ARE KNOWN BY: _____

DOB (MM/DD/YYYY): ____/____/____ SSN: _____-____-____ DRIVERS LICENSE _____

STREET ADDRESS: _____ APARTMENT # _____ State

CITY _____ STATE _____ ZIP _____

MAILING ADDRESS (IF DIFFERENT THAN ABOVE): _____

CITY _____ STATE _____ ZIP _____

HOME PHONE: (____)-____-____ MESSAGE OK? YES NO CELL PHONE: (____) _____-

PLACE OF EMPLOYMENT or SCHOOL ATTENDING: _____

WORK TELEPHONE NUMBER: (____)-____-____ MESSAGE OK? YES NO

~~ INFORMED CONSENT FOR TREATMENT ~~

As a client Salem Psychiatric Associates PC, is a multidisciplinary group practice. Any physician or therapist associated with SPA may review your records in part or in whole for the purposes of treatment, quality assurance or other health care operations. Otherwise, clinical records are kept under the strictest rules of confidentiality which means that information about your treatment will not be released to any outside agency or individual without your written permission. Please be advised, however, that rules of confidentiality will be broken under certain circumstances as SPA employees and subcontractors are required by law to report evidence of suicidal or homicidal intent, evidence of past or current child abuse and evidence of past or current elder abuse. Additionally, confidentiality may be broken in the event that the information we have could help save your life in a life-threatening emergency. If you have questions about confidentiality, please feel free to discuss them with your therapist.

~~ FEE AGREEMENT ~~

My signature below indicates that I have read the above information and am requesting mental health treatment from Salem Psychiatric Associates PC or its subcontracted providers. I hereby consent to treatment and take responsibility to pay for treatment. I have received and read a copy of the office policies. I understand that I will be charged for appointments that are missed or canceled with less than 24 hours notice and that my insurance will not be billed. I authorize this office to release any information necessary to expedite insurance claims to the insurance companies listed above or to any subsequent insurers, should my health insurance change. This includes information about psychiatric treatment and/or drug and alcohol treatment. This will include my diagnosis and for some insurers may also include my treatment plan or the full text of my chart.

SIGNATURE: _____ DATE: _____

I am the Patient _____ the Parent _____ the Guardian _____

I have received a copy of this form, the Consent to Treatment, and Fee Agreement _____
Initial here, please