South Street Health Services Family Health and Psychiatry NPS PLLC
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12 South Street
Lockport, NY 14094
716-727-0099

(Office Use Only)
Appointment Date _____
Time_____

Please return all forms (signed) in the enclosed postage-paid envelope as soon as possible. You may call for an appointment once all forms have been received. Appointments are not automatically scheduled.

Name _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Sex _____ Social Security Number _____

Marital Status (circle one): Married, Single, Other_____

Home Phone Number _____

Cell Phone Number _____

Emergency Contact (name & number) _____

Primary Insurance Carrier (Company) _____

Insurance ID# and Suffix _____

Secondary Insurance Carrier (Company) _____

Insurance ID# and Suffix _____

Referring Physician _____

Physician Address _____ Physician Phone Number_____

Pharmacy Name: _____

Pharmacy Address: _____ Pharmacy Phone Number _____

BRING YOUR INSURANCE CARD AND A LIST OF YOUR CURRENT MEDICATIONS TO YOUR APPOINTMENT!!!

1. Seeking Help With: _____
   _____
   _____
2. Current Psychiatric Medications: _____
   _____
   _____
   _____
3. Past Psychiatric History (including Psychiatrists, Therapists, and Medication):
   _____
   _____
   _____
4. Family Psychiatric History (including family history of alcohol and drug abuse):
   _____
   _____
   _____
5. Medical History (including Medications and Surgeries): _____
   _____
   _____
   _____
6. Allergies: _____
   _____
7. Use of Drugs and Alcohol: _____
   _____
   _____
   _____
   _____
8. Family History (Relationships, for example, with parents, siblings, and significant others):
   _____
   _____
   _____
   _____
   _____

New Patient Intake Form

Patient Information

Patient Name _____Sex (F/M) _____

Patient Date of Birth _____

Marital Status _____

Address_____

_____

Phone Number _____

Best Time/Day To Call _____

Email _____ Fax _____

Social Security # _____

Employer _____

Occupation _____

Emergency Contact Name _____

Relationship to Patient _____

Emergency Contact Phone Number _____

Responsible Party (If the patient is a minor (under the age of 18), the parent or guardian bringing the patient in will be listed as the guarantor)

Responsible Party's Name _____

Relationship to Patient _____

Date of Birth _____

Phone Number _____

Social Security # _____

Address _____

Additional Information

Email Address _____

Race (please select):

☐White ☐American Indian or Alaska Native

☐Asian ☐Black or African American

☐Hispanic ☐Native Hawaiian or Pacific Islander

☐Other ☐Decline

Ethnicity (please select one):

☐Hispanic or Latino ☐Not Hispanic or Latino

☐Decline

Preferred Language (please select one):

☐English ☐Sign Language

☐Bosnian ☐Spanish

☐Indian (including Hindi & Tamil) ☐Russian

☐Other _____

Preferred Pharmacy Name & Location _____

_____

I certify that I have read and agree to South Street Health Services payment policy. I am eligible for the insurance indicated on the Patient Insurance Information Form and I understand that payment is my responsibility regardless of insurance coverage. I hereby assign to South Street Health Services (SSHS) all money to which I am entitled for medical expenses related to the services performed from time to time by SSHS, but not to exceed my indebtedness to SSHS. I authorize SSHS to release any medical information to my insurance carrier or third-party payer to facilitate processing my insurance claims. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency. A $20.00 returned check fee will be charged for checks returned due to insufficient funds. I choose to receive communications from SSHS by text or e-mail at the number or address stated above, including but not limited to communications about appointments, treatment, and payment. I understand that such emails and texts may not be secure and there is a risk that they may be read by a third-party.

MEDICARE BENEFICIARIES: I request that payment of authorized Medicare benefits be made to South Street Health Services.

I have reviewed a copy of South Street Health Services' Privacy Notice ☐(Initials)

Signature of Responsible Party: x_____ Date: _____

Printed Name of Responsible Party: x_____

Date: _____

PATIENT RESPONSIBILITY FORM

1. INDIVIDUAL'S FINANCIAL RESPONSIBILITY

I understand that I am financially responsible for my health insurance deductible, coinsurance or non-covered service.
-Co-payments are due at time of service.
-If my plan requires a referral, I must obtain it prior to my visit.
-In the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided.
-If I am uninsured, I agree to pay for the medical services rendered to me at time of service.

2. INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

I hereby authorize and direct payment of my medical benefits to South Street Health Services Family Health and Psychiatry NPS PLLC, on my behalf for any services furnished to me by the providers**.**

3. AUTHORIZATION TO RELEASE RECORDS

I hereby authorize South Street Health Services Family Health and Psychiatry NPS PLLC, to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization or referral to other medical provider.

4. MEDICARE REQUEST FOR PAYMENT

I request payment of authorized Medicare benefits to me or on my behalf for any services furnished by me or in South Street Health Services Family Health and Psychiatry NPS PLLC. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

Signature of Patient, Authorized Representative or Responsible Party Date

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Print Name of Patient, Authorized Representative or Responsible Party

Patient Confidentiality Form

Patient Name: _____

Date of Birth: _____

Patient confidentiality is our top priority here at South Street Health Services. As providers/employees, we plan to keep all patient information completely confidential. We will also never disclose, share, or discuss your personal information without your signed consent.

South Street Health Services staff may leave messages regarding results (test/lab), scheduling (appointments, surgeries, and procedures) and billing information with the following:

☐ Spouse _____ ☐ Answering Machine At Home

☐ Voicemail At Work ☐ Voicemail On Cell Phone

☐ Other _____ Relationship_____

☐ South Street Health Services **MAY NOT** leave **ANY** information

Please list any family members who may obtain or call and discuss your medical information:

_____

_____

I understand that if the status of any of the information above changes, it will be my responsibility to inform the staff at South Street Health Services.

Patient Signature _____ Date _____

Patient Discharge Form

Patient Name _____

Date Admitted_____

Reason for Admittance_____

Diagnosis at Admittance _____

Describe the treatment taken. _____

Date Discharged _____

This discharge physician-approved?
Yes _____ No _____

Reason for Discharge (Check one):

- ❑ Patient Deceased
- ❑ Patient Treated
- ❑ Patient Transferred
- ❑ Patient Left Against Advice
- ❑ Other _____

Is future treatment needed?
Yes _____ No _____

Was patient prescribed medication?
Yes _____ No _____

Discharging Physician Name _____

Signature _____ Date _____