



GERALD D. CHITTERS, M.D.

Psychiatrist

Please return to:
Phone: 720.898.8711
Fax: 720-897-2833
e-mail: Jessica@arvadamentalhealthbilling.com

Please complete both sides and fax or e-mail to our office

PATIENT INFORMATION

NEW PATIENT

UPDATE

Patient Name

e-mail address

Date of Birth

Sex {M or F}

Social Security #

Home Phone

Marital Status

Spouse's Name

Work Phone

Street Address

Cell Phone or Pager

City

State

Zip Code

Patient Employer/School

City

Who may we contact in case of emergency? [List name and phone number]

How did you hear about us? Please give referral name and phone number.

A missed session will be charged at the regular rate if it is not cancelled 48 hours before the appointment. You will not be charged if we fill the time slot from the wait list. Monday appointments must be cancelled by 12 noon the Friday before.

INSURANCE INFORMATION

Please be advised that some medical diagnoses may affect your ability to get health and/or life insurance in the future. If an insurance company will be paying us directly or reimbursing you for your doctor visits you **must** call them **before** your first appointment with Dr. Chitters to verify prior authorization requirements. **In addition, please call our billing office at 720.898.9399 to give them the information necessary to bill the insurance company for your visits. Failure to do so may result in you being financially responsible for your sessions.**

I authorize the release of any information necessary to verify insurance coverage and to file a claim for insurance benefits related to professional services rendered, in compliance with HIPAA regulations.

Signature

Date

PAYMENT INFORMATION

Name of insurance company we will be billing on your behalf? _____
Please provide your insurance card for us to copy.

Or if private pay, please pay at time of service. We accept cash, check, or charge.

Responsible Party Information if different than patient:

Responsible Party's Name			
Street Address	City	State	Zip Code
Home Phone	Work Phone	Employer	

All billing will be the full financial responsibility of the parent the child resides with. Please make your own arrangements to receive any reimbursements from other parties.

MEDICAL INFORMATION

Relevant medical conditions [history, current condition, changes in condition]:

Medications [dosage, dates of initial prescriptions, name of prescribing professional]:

Allergies/adverse reactions to treatment:

Therapist Name: _____ Phone: _____

Primary Care Physician Name: _____ Phone: _____

Address: _____

I hereby give my permission to contact the above therapist and/or doctor to coordinate care:

yes no _____

Signature

Date

CONFIDENTIAL EXCHANGE OF INFORMATION FORM

Patient Name: _____

A. Treating Behavioral Health Clinician/Facility Information

Name: _____ Phone: _____

Address: _____ Fax: _____

B. Primary Care Physician/Medical Clinician Information OR other Behavioral Health Clinician:

Name: _____ Phone: _____

Address: _____ Fax: _____

1. The Patient is being treated for the following behavioral health problem(s):

- ADHD/Behavior D/O Anxiety D/O Adjustment D/O Bipolar Disorder D/O
 Depressive D/O Eating Disorder Substance Abuse Personality D/O
 Psychotic Disorder Other: _____

2. Outpatient care is being delivered and the treatment plan consists of (circle all that apply):

- Individual Psychotherapy Couples Therapy Family Therapy
 Group Therapy Medication Management Other:

3. Expected length of treatment: < 3 months 3-6 months 6-12 months > 1 year

4. Medication (s) are being managed by: _____

Medication(s) and Dosage(s):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Coordination of care issues/other significant information impacting medical or behavioral healthcare:

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION TO PRIMARY CARE
PHYSICIANS AND/OR OTHER HEALTH CARE PRACTITIONERS

Primary Care Physician/Health Care Practitioner Name: _____

Patient Name: _____

By initialing all information items I approve, I authorize release of the following medical information to the Health Care Practitioner named above. Check and initial all that apply:

- Mental Health Diagnosis _____
- Medication Management Information _____
- HIV/AIDS Related Records (Except HIV Test Results) _____
- Other Mental Health Treatment Information _____
- Other information specified here _____
- Substance Abuse (SA) Information _____

For SA Information, this authorization is:

- Limited to the following treatment _____

Limited to the following time period _____

OR

- I do NOT wish to have information shared with:
- My PCP/medical practitioner My other behavioral health clinician(s)/provider(s).

Confidentiality of alcohol and drug abuse patient records is protected under federal law. Federal regulations (42 CFR, part 2) prohibit anyone from making any further disclosure of the information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations.

I understand that the release of this information is to permit my treating physician and other health care practitioners to monitor my health status and to coordinate all the care which I may receive. This authorization, unless otherwise indicated, becomes effective on the date signed and may be revoked by me at any time, except to the extent action has been taken in reliance herein. If not earlier revoked or instructed, this authorization shall terminate automatically within one year of the date of execution. I understand that the information authorized by this release will be provided to those recipients only with signed consent from me. I further understand that I have a right to receive a copy of this authorization upon my request.

Signature of Patient or Legal Guardian Date

Please place a completed copy of this form in the patient's medical record.

DATE FORM __ MAILED or __ FAXED TO OTHER CLINICIAN / FACILITY: _____

__ NOT APPLICABLE – PATIENT DOES NOT CONSENT TO RELEASE OF INFORMATION.

NOTICE: EFFECTIVE March 31, 2010

Our policy is that we require a minimum of 48 hours notice to try to fill your time slot if you must cancel. Monday appointments must be cancelled by Thursday morning. Late cancellations and no-shows for ½ hour sessions will be charged \$100.00, \$170 for hour sessions. Insurance does not pay for these. Please allow yourself enough extra time to get to your session on time, considering traffic accidents, construction delays, and bad weather. Thank you for your consideration of the doctor's time.

Signature

Date