

**THE PISGAH INSTITUTE FOR PSYCHOTHERAPY AND EDUCATION, P.A.**

DOCTOR/CLINICIAN YOU WILL BE SEEING: \_\_\_\_\_ DATE BEING SEEN: \_\_\_\_\_

**PATIENT INFORMATION**

NAME \_\_\_\_\_  
FIRST MIDDLE LAST PREFERRED TO BE CALLED

MAILING ADDRESS \_\_\_\_\_  
CITY STATE ZIP

RESIDENCE ADDRESS \_\_\_\_\_  
(IF DIFFERENT FROM MAILING ADDRESS)

OCCUPATION \_\_\_\_\_ EMPLOYER \_\_\_\_\_

HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ S.S.N. \_\_\_\_\_ SEX:  Female  Male

Ethnicity: \_\_\_\_\_  DECLINED Race: \_\_\_\_\_  DECLINED

MARITAL STATUS:  SINGLE  MARRIED  SEPARATED  DIVORCED  WIDOW/WIDOWER  DOMESTIC PARTNER

IS THE PATIENT:  SELF  MINOR  SPOUSE  OTHER (EXPLAIN: \_\_\_\_\_)

IS THE PATIENT A STUDENT?  NO  YES and:  FULL-TIME  PART-TIME

PATIENT EMPLOYER (IF APPLICABLE): \_\_\_\_\_

**INSURANCE INFORMATION**

*(If primary insured/card holder **is not patient** complete INSURANCE INFORMATION section)*

**Primary Insurance**

PRIMARY CARDHOLDER'S NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
CITY STATE ZIP

HOME PHONE: \_\_\_\_\_ WORK PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_

S.S.N.: \_\_\_\_\_ EMPLOYER'S NAME: \_\_\_\_\_

CARDHOLDER'S RELATIONSHIP TO PATIENT:  SPOUSE  PARENT  OTHER: \_\_\_\_\_

*(We will not file secondary insurance policies unless you have Medicare as a primary insurance; See Financial Agreement)*

**Secondary Insurance**

SECONDARY CARDHOLDER'S NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
CITY STATE ZIP

HOME PHONE: \_\_\_\_\_ WORK PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_

S.S.N.: \_\_\_\_\_ EMPLOYER'S NAME: \_\_\_\_\_

CARDHOLDER'S RELATIONSHIP TO PATIENT:  SPOUSE  PARENT  OTHER: \_\_\_\_\_

**RESPONSIBLE PARTY FOR BILLING:**

SELF  OTHER (If "Other" complete *RESPONSIBLE PARTY PAYMENT FORM*)

**OUTSIDE CONTACT INFORMATION**

PRIMARY CARE PHYSICIAN: NAME: \_\_\_\_\_

IN CASE OF EMERGENCY, CONTACT: NAME: \_\_\_\_\_

PHONE: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

Referring Dr. (if applicable): \_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_ Phone: \_\_\_\_\_

**INSTRUCTIONS:** Read the following carefully and sign in the space provided below of each applicable section.

**SELF-PAY**

I have no insurance coverage. Therefore, I understand that I am responsible for payment of services rendered to myself or my dependents at the time of service.

\_\_\_\_\_  
Date \_\_\_\_\_  
SIGNATURE OF PATIENT/LEGAL GUARDIAN/RESPONSIBLE PARTY

**INSURANCE AUTHORIZATION AND ASSIGNMENT**

I hereby authorize the Pisgah Institute to release any information necessary to process insurance claims and request payments of benefits to be made to the Pisgah Institute for services rendered to myself or my dependents. I understand that I am responsible at the time of service for paying any required co-payment and deductible.

\_\_\_\_\_  
Date \_\_\_\_\_  
SIGNATURE OF PATIENT/LEGAL GUARDIAN/RESPONSIBLE PARTY

**FINANCIAL AGREEMENT**

I have read, understand, and signed the Patient Financial Agreement.

\_\_\_\_\_  
Date \_\_\_\_\_  
SIGNATURE OF PATIENT/LEGAL GUARDIAN/RESPONSIBLE PARTY

**AUTHORIZATION AND CONSENT FOR TREATMENT**

I hereby grant my authorization and consent to treatment and procedures deemed appropriate and certify that no guarantee or assurance has been made as to the results which may be obtained. I also give my consent for my personal health information to be shared with any other clinicians within Pisgah Institute to which I have been referred.

\_\_\_\_\_  
Date \_\_\_\_\_  
SIGNATURE OF PATIENT/LEGAL GUARDIAN/RESPONSIBLE PARTY

**MEDICAL RECORDS**

While patients are entitled to access their medical records, requests are contingent upon the discretion of the patient's clinician(s) for approval of the medical record request and therefore may take several days to process.

\_\_\_\_\_  
Date \_\_\_\_\_  
SIGNATURE OF PATIENT/LEGAL GUARDIAN/RESPONSIBLE PARTY

**PRESCRIPTION PROCESSING**

There is a 72-hour processing time for prescription requests, including refill requests. Requests for refills that are received after noon on Friday will not be called in until Monday. Patients should allow for this processing time. There is a \$15 charge per prescription including refills, written, called in, or faxed outside of a scheduled appointment.

\_\_\_\_\_  
Date \_\_\_\_\_  
SIGNATURE OF PATIENT/LEGAL GUARDIAN/RESPONSIBLE PARTY

- |                       |                          |                            |                        |
|-----------------------|--------------------------|----------------------------|------------------------|
| Bill Barley, Ph.D.    | Nancy McKeel, Ph.D.      | Laura Bradley Yurko, M.A.  |                        |
| Stephen E. Buie, M.D. | Andrea Meckley, M.A.     | Doug McKee, Psy.D.         | Ashley Dorough, Psy.D. |
| Ed Hamlin, Ph.D.      | Steve Gold, Ph.D.        | Amy Palmer, Ph.D.          | Caroline Lewis, M.D.   |
| Jeff Carter, M.D.     | Mary Ammerman, Psy.D.    | Pam Rogers, P.N.P.         | Sarah Wells, M.D.      |
| Mary Berg, M.D.       | Judy McKay, M.D., M.P.H. | Danielle Mitchener, A.N.P. |                        |
| Susan Hill, Ed.D.     | Terry Sloan, M.S.        | Richard Johnson, Ph.D.     |                        |



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## **Patient Financial Agreement**

The management of mental health benefits has become very complex and time consuming. We try to be accurate when informing you of your benefits, but as the insurance companies clearly state, “**benefit information is not a guarantee of payment.**” We, therefore, cannot be certain of your account balance until after we receive payment from the insurance company.

- You are responsible for knowing whether your insurance covers our services and the provider you are seeing. There are customer service numbers on your insurance card or ask your employer.
- Co-payments are due at the time of service. This is the **TOTAL** of what the insurance does not pay. If co-payments are not made, we may be unable to continue to provide service.
- **If your balance exceeds \$200.00 you must speak to the collections coordinator prior to further treatment.**
- Insurance policies are contracts between you and your insurance company. We file claims as a courtesy and try to help with problems, but you will need to resolve those beyond our control. If insurance is not paying within a reasonable time you will be responsible for the full payment.
- We will provide a courtesy filing of your secondary insurance however you may still be responsible for what your primary insurance does not cover if there are delays with your secondary insurance.
- If your provider is not covered by your insurance company, full payment is due when services are provided.
- Phone consultations will be charged for. These are not covered by insurance. Phone consults are defined as phone calls made to/from the patient’s doctor or the doctor-on-call outside of a scheduled appointment and/or office hours.
- Prescriptions and refills are charged \$15 per prescription written, called in, or faxed outside of a scheduled appointment.
- There are charges for missed appointments and late cancellations\*.  
\*Late cancellations are any appointments cancelled less than 24-hours prior to the appointment.

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SIGNATURE

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DATE

**The Pisgah Institute  
158 Zillicoa St.  
Asheville, NC 28801**

**Notice of Privacy Practices  
Written Acknowledgement Form  
(Copy upon request)**

I, \_\_\_\_\_, have been offered  
a copy of The Pisgah's Institute's Notice of Privacy Practices.

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Date

The Pisgah Institute for Psychotherapy & Education, P.A.  
Mental Health Authorization for Disclosure of Protected Health Information (PHI)

For office use only:

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

I authorize The Pisgah Institute, P.A. and its employees to inform the following person(s) of my appointment time(s).

\_\_\_\_\_  
Person's name

\_\_\_\_\_  
Relationship to patient

\_\_\_\_\_  
Person's name

\_\_\_\_\_  
Relationship to patient

I understand that this authorization is revocable except to the extent that action has been taken in reliance thereon, and this authorization shall remain in force for one year or until (Date): \_\_\_\_\_, 20\_\_\_\_

\_\_\_\_\_  
Signature of Patient, Parent (for minor or child), Legal Guardian, or Authorized Representative

\_\_\_\_\_  
Date