

*Fairfield Psychological Associates, P.C.*

5265 Providence Road, Suite 500/501, Virginia Beach, VA 23464

Office: (757) 467-9500 Fax: (757) 467-9560

**PATIENT INFORMATION:**

**PLEASE WRITE YOUR NAME EXACTLY AS IT APPEARS ON YOUR INSURANCE CARD!**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Sex: male / female Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Cell #: \_\_\_\_\_ Home #: \_\_\_\_\_ Work #: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

**RESPONSIBLE PARTY:**

If you are over the age of 18, you are your own responsible party OR parent/ guardian information for all patients under 18 (responsible party MUST sign paperwork)

Relationship to Patient: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Sex: male / female Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_

Employer: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Cell #: \_\_\_\_\_ Home #: \_\_\_\_\_ Work #: \_\_\_\_\_

**PATIENT INSURANCE INFORMATION:**

Primary Insurance Carrier: \_\_\_\_\_

Identification #: \_\_\_\_\_

Secondary Insurance Carrier: \_\_\_\_\_

Identification #: \_\_\_\_\_

I hereby assign insurance benefits to Fairfield Psychological Associates, P.C. I acknowledge that I am voluntarily seeking services and understand that insurance may be filed as a service on my behalf. I also acknowledge that I am to be personally responsible for collection fees if &/or when the account becomes delinquent & collection proceedings are required.

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Patient Name (PLEASE PRINT)

Date

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Patient OR Responsible Party Signature

Date

This form is utilized to establish a clear understanding regarding the details of your financial account with this practice. Your signature is an acknowledgement of your understanding & agreement with the provisions of these statements.

I agree to be responsible for **payment in full** of the charges for professional services rendered by Fairfield Psychological Associates, P.C. to the patient mentioned below. **INITIAL HERE** \_\_\_\_\_

Fairfield Psychological Associates will file insurance claims on behalf of the patient for rendered services. Insurance payment shall be made to the practice. Should payment be made to the patient or responsible party by the insurance carrier, the responsible party agrees to **promptly forward the payment to the practice or pay the balance due themselves.** **INITIAL HERE** \_\_\_\_\_

The patient or responsible party **must pay the co-payment at the time services are rendered.** This is the amount which is estimated as not being covered by the patients insurance. I am also acknowledging that it is my responsibility to inform the office **immediately** if there is **any change with my insurance.** **INITIAL HERE** \_\_\_\_\_

The **responsible party shall pay any outstanding balance** which is **not covered by insurance** which includes but is not limited to **deductible, co-payment, denied claims, no shows, &/or medication refill fees.** The patient or responsible party may receive a statement when there is an outstanding balance. The responsible party, **not the insurance company,** is ultimately responsible for the payment of the rendered services. **INITIAL HERE** \_\_\_\_\_

It is understood that the usual & customary collection procedures will be initiated should the **account become 90 or more days delinquent.** It is also understood that any **collection fees, including court costs, will be payable by the responsible party.** **INITIAL HERE** \_\_\_\_\_

It is understood that after **two** missed appointments (EX: No show, late cancel, same day cancel, etc.) we will no longer be able to provide you with the care you need. This will result in a dismissal from Fairfield Psychological Associates. **INITIAL HERE** \_\_\_\_\_

I understand that if I am **7 minutes late or more for any medication appointment,** I will be declared a no show which will incur a **no show fee of \$75** & my appointment has to be **rescheduled to another date &/or time.** The no show fee **MUST** be paid **IN FULL** in order to reschedule. **INITIAL HERE** \_\_\_\_\_

I agree if I am in need of a refill of any of my medications **outside** of my scheduled appointment, a refill fee of **\$25 per medication** must be paid **in full** in order to receive any refills. I also understand **refills of controlled medications outside of an appointment are PROHIBITED.** This means it is my responsibility to keep my prescriptions in a safe place & take them as they are prescribed to me. **INITIAL HERE** \_\_\_\_\_

I understand that as a patient of Fairfield Psychological Associates I **MUST** give **at least 24 business hour notice** to cancel &/or reschedule any appointment. I acknowledge 24 business hours does not include **weekends &/or after office hours.** **INITIAL HERE** \_\_\_\_\_

I understand that the responsible party must pay any balance incurred from copays, deductibles, no show fees, etc. within **90 days** in order to avoid collections. **INITIAL HERE** \_\_\_\_\_

If this account is referred to an attorney for collection, then the undersigned person(s) promise & agree to pay all collection costs including attorney fees of 33 1/3% of the principal amount due & owing when turned over for collection & do further agree to pay interest at a rate of 1 1/2% per month (18% per Annum) on the unpaid balance from the date the services were last rendered. I authorize photocopies of this form to be as valid as the original. In the event this matter is turned over for collection, I hereby expressly give permission for my current employer(s) to provide verification of my said employment to this office, or their attorney, Credit Control Corporation.

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**Patient OR Responsible Party Signature**

**Date**

The following policies are in place to provide timely & efficient care to all clients. Please read this page in its entirety. Your signature is an acknowledgment of your understanding & agreement with the provisions of the following policies of Fairfield Psychological Associates.

By signing this document, I am acknowledging that I am aware if I need **any** paperwork completed by my FPA provider, I will require **a separate appointment specifically for the completion of paperwork!** I **must** let the receptionists know when scheduling in order to schedule the appointment for the appropriate time needed to complete the paperwork within that session. Appointments for paperwork **must** be thirty (30) minutes long. If I have time sensitive paperwork, the receptionists will do their **best** to fit me in when needed. Any paperwork completed **is subject to a paperwork fee of \$25- \$150 that must be paid in full** before the completed paperwork is released. All fees & appointments are at the **complete discretion** of my FPA provider & their availability. I understand my FPA provider is **not** obligated to complete any paperwork.

By signing this document, I am acknowledging that I am aware if I am **seven (7) minutes late or more** for my **medication appointment**, I will be declared a no show which will result in the **\$75 no show fee** that must be paid **in full** before my medication appointment will be **rescheduled** to another date/ time. **Please note: Medication checks are fifteen (15) minutes long.** I am also acknowledging that if I am to run out of medication before my rescheduled appointment with any medication provider in this office, there is a **\$25 prescription refill fee** that must also be paid **in full** in order to receive a refill of my medications. Please allow at least **twenty-four (24) to forty-eight (48) business hours** for your medication provider to process your refill request. **Please note: Insurance companies do not pay for missed appointment fees, cancelled appointment fees, &/or medication refill fees.**

By signing this document, I am acknowledging that I am aware that due to prescribing guidelines in the state of Virginia, **any & all controlled medications will not be refilled outside of my medication appointment.** Office staff will attempt to accommodate any needs; However, it is **highly suggested** to schedule your follow-up appointment **before** leaving this office.

By signing this document, I am acknowledging that I will take my medication as I am **instructed to & not change the way I take it** without first consulting with my FPA provider or other member of the treatment team.

By signing this document, I am acknowledging that I will treat the staff of Fairfield Psychological Associates **respectfully at all times**. I understand that if I am disrespectful to staff &/or disrupt the care of other patients I will be **dismissed from the practice effective immediately & I will lose the ability to return**.

By signing this document, I am acknowledging that I understand Fairfield Psychological Associates is **strictly an outpatient facility**. While the office staff will do their best to accommodate, if I am to need **immediate emergency care**, I **must call 911** or admit the person(s) in need to **The Virginia Beach Psychiatric Center** without any hesitation.

By signing this document, I am acknowledging that it is my **sole responsibility as a patient** of Fairfield Psychological Associates to schedule follow-up appointments with the front desk staff. I understand I am also **solely responsible** for keeping track of my own appointments I schedule with my FPA provider as **reminders** from the office are system generated & a **courtesy**.

By signing this document, I am acknowledging that I will **not** receive **any medications from any other provider** without the **knowledge & consent** of my provider in this office. If I am to receive any medications without first consulting my provider in this office, this will result in **immediate dismissal** from Fairfield Psychological Associates.

By signing this document, I am acknowledging that I understand that I may lose my right to treatment in this office if I break any of the policies of Fairfield Psychological Associates.

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Patient OR Responsible Party Signature

Date

We ask that you please be considerate when cancelling &/or rescheduling appointments with your provider here at Fairfield Psychological Associates. While unfortunate events happen that are unavoidable, your scheduled appointment is very important to both your provider & you, therefore, please consider the following:

- Office hours are Monday through Friday from 9AM to 5PM.
- **Twenty-four (24) business hour notice is required to cancel &/or reschedule your appointment.**

- Messages after hours or on the weekends are **not** considered twenty-four (24) business hour notice.
- We **do not** monitor emails &/or voicemails on the weekends or after office hours.
- Reminder emails are system generated & sent to you as a **courtesy**. **Please note: Appointments are the sole responsibility of the patient/ guarantor.**
- We ask that you please **do not text, email, or call the personal cell phone** of your provider for any reason what-so-ever.
- Please contact the front office at (757)467-9500. If your call goes to voicemail, we ask that you please leave **one (1) voicemail** with **your name, the patients name (if applicable), the patients date of birth, the reason you are calling, & the best phone number to reach you.** The office staff will return your voicemail within **twenty-four (24) to forty-eight (48) business hours.** If you are in need of **emergency care** or in **crisis**, without any hesitation, utilize **911 &/or The Virginia Beach Psychiatric Center.**
- All phone calls will be handled by the front office & forwarded to the appropriate provider if need be.

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Patient OR Responsible Party Signature

Date

Please initial on the lines provided below.

\_\_\_\_\_ I will **not** accept **any controlled substances from another doctor** without first consulting with my FPA provider.

\_\_\_\_\_ I will be responsible for making sure I **do not run out of my medication** before my appointment with my medication provider.

\_\_\_\_\_ I understand that I **must** keep my **medication** in a **safe place**.

\_\_\_\_\_ I understand that my medication provider will **not** supply or replace any **prescriptions** if they are **lost, misplaced, &/or stolen**.

\_\_\_\_\_ I understand that if my medication is **stolen**, my medication provider may provide me with a refill **one (1) time only** if a **police report** is made & a **copy** of said police report is submitted to the front office staff. **Please note: Replacement scripts are at the complete discretion of my medication provider & if given will require a \$25 refill fee paid in full before I am able to receive new prescriptions.**

\_\_\_\_\_ I will **not** give my **prescription** to **anyone else**.

\_\_\_\_\_ I **will keep** all of my **regularly scheduled appointments** with my medication provider.

\_\_\_\_\_ I agree to **refrain** from **any & all addiction drugs &/or alcohol** while taking my medications.

\_\_\_\_\_ I agree to **random urine drug screens**.

\_\_\_\_\_ I agree to take my medications **exactly as they are prescribed to me** unless first consulting with my medication provider to make a documented change.

\_\_\_\_\_ I understand that **any & all controlled medications** will not be refilled outside of an appointment with my medication provider. **No exceptions.**

\_\_\_\_\_ I agree that **any infractions** of any & all of the statements listed above, misuse of prescriptions, etc. will result in **immediate dismissal** from Fairfield Psychological Associates.

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Patient OR Responsible Party Signature

Date

HIPAA AUTHORIZATION FORM

Name of Patient (Please PRINT): \_\_\_\_\_

Patients Date of Birth: \_\_\_\_\_

I hereby authorize Fairfield Psychological Associates, P.C. to release &/or discuss protected health information about the patient named above to the entities listed below:

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**Please list name(s) of all parties authorized to receive specified information**

I authorize the parties listed above to receive the following information (Please circle all that apply):

**All Medical / All Financial / Appointments Only / All Information**

This authorization shall expire on:

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**(If I fail to provide an expiration date, this authorization will expire six months from the date signed)**



I understand that I have the right to revoke or amend this authorization at any time & that I have the right to inspect or copy the protected health information I wish to be disclosed to the parties listed in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient & may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization & that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

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**Patient OR Responsible Party Signature** **Date**

Why are you currently seeking treatment?

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Please list any & all medical conditions:

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Have you had any psychiatric hospitalizations? Yes or No If yes, how many times, where, & when?

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Please list your previous mental health, therapy, &/or medication providers:

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Please list all current medications:

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Please list the name, location, & phone number of your pharmacy:

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Please list previous mental health medications that have been tried:

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Please give a brief mental health history:

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# *Fairfield Psychological Associates*

5265 Providence Road, Suite 500

Virginia Beach, Virginia 23464

Phone (757) 467-9500. Fax (757) 467-9560

[www.fairfieldpsych.com](http://www.fairfieldpsych.com)

Fairfield Psychological will now offer text message and telephone calls in addition to the e-mails sent by our electronic health record system.

Please note that reminders are still a courtesy and maintaining all scheduled appointments are still the responsibility of the patient/guarantor. All appointments must still be cancelled or rescheduled 24 business hours in advance. Any appointments not cancelled within 24 business hours are subject to the \$75 fee. Insurance does not pay for missed/cancelled appointments.

**PATIENT NAME:** \_\_\_\_\_

**PARENT/GUARDIAN NAME (if patient is a minor):** \_\_\_\_\_

\_\_\_\_\_ **YES** – I would like to receive Phone Calls and Text Messages for appointment reminders (2 days prior).

\_\_\_\_\_ **YES** – I would like to receive Email Messages for appointment reminders (1 week prior, and then follow up email 1 day prior).

\_\_\_\_\_ **NO** – I would NOT like to receive Text Messages and Phone Calls for appointment reminders.

\_\_\_\_\_ **NO** – I would NOT like to receive Emails for appointment reminders.

**Mobile Number for Text Messages:** (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Telephone Number for Reminder Calls:**(\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**MOBILE PROVIDER:** \_\_\_\_\_

**Email Address for Email Reminders:** \_\_\_\_\_

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**SIGNATURE**

**DATE**