

Please complete all information on the enclosed forms and if possible please send us a copy of the front and back of your insurance card so that we may verify your coverage. If you could please return this packet as soon as possible, this would be greatly appreciated. We will not be able to schedule your appointment until this packet is returned with all information completed and your insurance has been verified.

Return Address: 9141 Cypress Green Drive, Suite 1
Jacksonville, FL 32256
Phone: (904) 733-7333 Fax: (904) 779-3239

**What is the best number for us to contact you for your appointment?

**May we leave a message?

_____ yes _____ no

**When is the best time for us to call?

**Were you referred to a specific provider in our office? _____

If so, please name: _____

**Referring Physician's name and number: _____

**Are you currently under the care of a Psychiatrist? _____

If so, please name: _____

**Would you be interested in participating in our Clinical Trials? _____

Dr. Vijapura & Associates
9141 Cypress Green Drive, Suite 1
Jacksonville, FL 32256
Ph ~ (904) 733-7333 Fax ~ (904) 779-3239

Patient Registration

Name: _____ SS#: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Date of Birth: _____ Marital Status: _____ S M W Sep D
Telephone: Home: _____ Office: _____ Cell: _____
E-Mail Address: _____
Referred By: _____
Employer name: _____ Occupation: _____
Emergency Contact Information: _____

IF PATIENT IS A MINOR, WHO IS THE LEGAL GUARDIAN _____
(MINOR PATIENT MUST BE ACCOMPANIED BY A LEGAL GUARDIAN OR HAVE POWER OF ATTORNEY
TO MAKE MEDICAL DECISIONS FOR MINOR PATIENT - COPY OF POWER OF ATTORNEY REQUIRED)

INSURED PERSON (if not above named patient)

Name: _____ DOB _____ SS# (required): _____
Address (if different from above): _____
City: _____ State: _____ Zip Code: _____
Employer: _____ Relationship to Patient: _____

INSURANCE INFORMATION (see listing of participating insurance companies)

Primary Insurance Carrier: _____
ID#: _____ Group#: _____ Phone #: _____

Secondary Insurance Carrier: _____
ID#: _____ Group#: _____ Phone #: _____

MEDICAL INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process this claim. This authorization may be revoked by either me or my insurance company at any time in writing.

I authorize Dr. Vijapura to apply for benefits on my behalf for covered services rendered by him or his order. I request that payment from my insurance company be made directly to Dr. Vijapura (or to the party that accepts assignment).

I certify that the information I have reported with regard to my insurance is correct.

Date: _____ Signature: _____

Dr. Amit Vijapura and Associates
Intake Questionnaire – Adults

Name: _____ Date: _____

Put a check next to any of the following that have been a significant problem for you during the past month:

- Difficulty with getting things organized
- Forgetting important things
- Being easily distracted by noise or activity around you
- Feeling restless or fidgety
- Feeling easily bored
- Irritability or impatience
- Worrying too much
- Muscle tension
- Feeling easily overwhelmed
- Feeling sad or down
- Lack of pleasure in activities
- Fatigue/low energy
- Guilt
- Trouble with sleep
- Low self worth
- Anxiety attacks/panic attacks
- Feeling that your mind is moving too fast
- Acting impulsively
- Intrusive thoughts about traumatic experiences
- Feeling embarrassed too easily
- Substance Abuse
- Alcoholism
- Medical problems i.e. epilepsy, diabetes, heart conditions, major surgery, high blood pressure, irregular menstrual cycle: _____

Describe the problem(s) you most want us to help you with:

List any medications that you currently taking:

Amit Vijapura, MD
9141 Cypress Green Dr., Suite 1
Jacksonville, FL 32256
Ph: 904-733-7333 Fax: 904-779-3239

Insurance Information

We accept the following insurance carriers:

Blue Cross Blue Shield PPO

Cigna PPO / HMO

Tricare

United HealthCare/United Behavioral Health

If you are unsure about our acceptance of your Insurance, obtain a copy of your
Provider Directory from your Insurance Carrier

INSURANCE ASSIGNMENTS AND AUTHORIZATIONS

1. RELEASE OF INFORMATION: I, the below named patient or guardian, do hereby authorize any physician examining and/or treating me to release to third payer (such as insurance company or governmental agency) any medical, psychiatric condition, alcohol or drug related condition and records concerning diagnosis and treatment when requested by such third party for its use in connection when determining a claim for payment for such treatment and/or diagnosis.

2. PHYSICIAN INSURANCE ASSIGNMENT: I, the below named subscriber, hereby authorize payment directly to the physician examining or treating me of medical benefits herein specified and otherwise payable to me for their services as described, but not to exceed the reasonable and customary charge for these services.

3. I PERMIT A COPY OF THIS AUTHORIZATION AND ASSIGNMENT TO BE USED IN PLACE OF THE ORIGINAL THAT IS ON FILE AT THE PHYSICIAN'S OFFICE. This assignment will remain in effect until revoked by me in writing.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. I understand it's my responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by my insurance or third payer within a reasonable period of time not to exceed 90 days.

If this account is assigned to an attorney for collections, the prevailing party shall be entitled to reasonable attorney fees and cost of collections.

I have read and understand the Office Policies for Dr. Amit Vijapura and Associates.

Patient's signature: _____ Date: _____

Guardian's signature: _____ Date: _____

WHAT PATIENT'S SHOULD KNOW ABOUT DR. AMIT VIJAPURA AND ASSOCIATES

We are a group practice, which means we work closely together to provide evaluation, education and treatment for a whole range of emotional and mental disorders as well as substance abuse.

HOURS

Our office hours are 9:00am to 5:30pm Monday, 9:00am to 6:30pm Tuesday and Thursday, 8:00am to 5:30pm Wednesday, and 9:00am to 2:00pm Friday.

APPOINTMENTS

Appointments may be scheduled for 15 minutes or up to 1 hour depending upon your needs, the service being provided and the individual practitioner.

Once an appointment is scheduled, this time is reserved for you. In order for us to see all of our clients at the scheduled time, it is extremely important that you arrive on time for your appointment. If you find that you are unable to keep an appointment, please notify us at least 24 hours in advance, so that someone else can be scheduled during that time. Please note: You will be charged a \$50.00 fee for appointments cancelled without 24 hour notice and a \$50.00 fee if you No show for a scheduled appointment. Please be aware that insurance companies will not pay for missed appointments. Please note: We do not call in refill requests or provide a prescription if follow up appointments have not been kept.

Please initial here stating you understand our policy

FEES AND PAYMENTS

For your convenience, we accept cash, checks, Visa, Mastercard, Discover and American Express.

There is a \$25.00 fee for returned checks.

Our fees are based on time and skill, as well as overhead factors. It is our goal to provide you with the best possible service for the fees we charge. In order to keep our overhead as low as possible, we require payment of all co-payments and deductibles, at the time of service. If for any reason this is not possible, financial arrangements must be made prior to your visit. Any balance past due sixty (60) days or more will incur a \$15.00 per month late fee. Balances that are substantially past due will be turned over to a Collection Agency and reported to the Credit Bureau.

Please initial here stating you understand our policy

There will be a charge for telephone conferences between you and your provider. The fee will depend on the length of the conversation. Insurance does not cover this fee and therefore it will be your responsibility to pay for this charge. Initial

There will be a fee for any letters or forms that are written on your behalf. The fee will depend on the length of the letter or forms. Insurance will not cover this fee and therefore it will be your responsibility to pay for this charge. Payment is required prior to any paperwork being released. Initial

INSURANCE

There are several things that you should know about insurance coverage for mental health care:

Your insurance company may require prior approval of any mental health services, EVEN IF THIS IS NOT SO FOR MEDICAL SERVICES. They may also limit the number of visits or the amount they authorize may be less than the maximum number of visits indicated in your policy. We attempt to make sure that all conditions of your policy are met, including pre-approval, so that you will not incur expenses your insurance company will not pay for. Please remember though, this is a courtesy we provide. YOU are ultimately responsible for being familiar with your policy's requirements and meeting them, as well as keeping track of their limitations.

At the time of your visit, you are required to pay your co-payment, any deductible not already met and any past due balance. We will bill your insurance for the remainder.

If the insurance company denies your claim, we will make every attempt to find and correct any problem. However, if insurance refuses to cover your claim or we do not receive payment within two (2) months of the date of service, you are responsible for the full amount of the bill. Initial

I have read, initialed and understand all of the office policies outlined in this New Patient Packet provided by Dr. Amit Vijapura and Associates.

Signature: _____

Date: _____

New Patient/Insurance Information

Any false information provided to us on your new patient paperwork will result in patient termination. If you have insurance coverage and do not indicate the information on your new patient paperwork, you will be terminated as a patient. This will not apply if we do not participate with your insurance carrier. Contact the office for an insurance listing.

Initial _____

Fees:

It is mandatory that **ALL** patients make payment at the front desk **PRIOR** to every visit. This includes full payment, co-payment, deductible, co-insurance, no show fees, misc. fees or outstanding balance. We try to assist our patients in billing their insurance **however** we are **NOT responsible for any DENIAL or non payment by the insurance company.** When we agree to provide services to you, full payment for services is your responsibility.

Any outstanding balance of 90-120+ days with no attempt to pay will be turned over to Collections. Please talk to the Office Manager to discuss payment arrangements. We are enforcing this policy due to the high number of outstanding balances. Also, please remember **once your account is turned over to collections, it is out of our hands and there is nothing we can do, you MUST CONTACT the agency and you will NO LONGER be eligible as a patient in the future.**

Initial _____

Cancellations:

Therapy appointments that are canceled less than 24 hours in advance will be charged \$75.00 for the time set aside. Please call only during business hours to change any appointments. Psychiatric appointments that are canceled less than 24 hours in advance will be charged \$50.00.

THIS POLICY WILL BE STRICTLY ENFORCED DUE TO THE NUMBER OF NO SHOWS.

Initial _____

Special Forms:

Request for special forms such as Medical Leave/Disability will be subject to a **FEF** to fill out forms. If you are requesting a copy of medical records the fee charged is **\$1.00 per page.**

These services are NOT covered by your medical insurance and payment will be due PRIOR to releasing forms/medical records.

Initial _____

Refills/Prior Authorization for Medications:

We no longer call prescription refills to pharmacies. Make sure when you leave that you have enough medication to last until your next appointment. There will be a **\$10.00 fee (per prescription) if they are lost or stolen. Stolen prescriptions require a POLICE REPORT. If your prescription required a Prior Authorization, you will be responsible for a \$25.00 fee per prescription. You also have the option to speak to the Doctor to have the prescription changes to a drug that does not required authorization.**

Initial _____

CREDIT CARD USAGE FOR PAYMENT

IF YOU USE A CREDIT CARD FOR PAYMENT AND IT DOES NOT HAVE YOUR NAME ON IT AS THE CARDHOLDER WE WILL REQUIRE A NOTARIZED STATEMENT FROM THE CARDHOLDER IN ORDER TO USE IT FOR PAYMENT!

Initial _____

Our Business Hours:

Mon 9:00am – 5:30pm. Tues 9:00am – 6:30pm. Wed 8:30am – 6:00pm. Thurs 9:00am – 6:30pm Fri 9:00am – 2:00pm.

Thank You for your assistance in these matters. ~~~ Kathryn Kennedy, Office Manager

Sign: _____

Date: _____