Dr. Stephen Brown & Associates

2417 EAST 15TH STREET
CASPER WYOMING 82609

Patient Information

Patient's Full Name: _____
Last First Middle/Maiden
Street Address _____
Mailing Address (PO Box) _____
City _____ ST _____ Zip _____
Date of Birth _____/_____/_____ Sex_____ Social Security Number _____
Marital Status _____ Spouse's Name _____
Home Phone _____ Cell/Message Number: _____
Employer/School_____ Work Phone _____ Cell phone _____
Primary care physician _____

Guardian Information

Guardian's Full Name _____
Last First Middle/Maiden
Relationship to Patient_____
Street Address _____
Mailing Address (PO Box) _____
City _____ST _____ Zip _____
Date of Birth _____/_____/_____ Sex_____ Social Security Number _____
Marital Status _____ Spouse's Name _____
Home Phone _____
Employer _____ Work Phone_____
*Who is responsible for payment of the bill?_____
* Note: Billing a non-custodial parent is a courtesy. No-Show fees are the guardian's responsibility

IN THE EVENT OF AN EMERGENCY, WHOM SHOULD WE CONTACT?
Name _____ Phone # _____
Relationship _____

Other Members in the Household

Name(s) First, Middle, Last	Birthdate (MM, DD, YYYY)	Relationship to PATIENT
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

Next of Kin:
Name: _____ Phone # _____

Please list family members or other persons, if any, who we may inform about your general medical condition and your diagnosis:

Name _____ Phone # _____
Relationship _____
Name _____ Phone # _____
Relationship _____

Insurance Information

Do you have medical insurance? ☐ Yes ☐ No
If you have insurance, please provide the billing clerk with copies of your insurance cards (both front and back), including Medicare.
If at ANY time, your insurance status changes, please notify our office as soon as possible
Insurance Company: _____
Insurance Company Claims Address: _____
Phone #s: Claims _____ Pre-certification _____ Provider line _____
Group #: _____ Policy #: _____
Insurance effective date: _____ Insured's date of birth: _____
Insured Party: _____ Insured's employer _____
Insured's address & phone number (if different) _____

Financial Agreement and Authorization for Treatment:

I authorize treatment of the person named above and understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance of my account for any professional services rendered. **I agree to pay all charges unless arrangements are agreed upon in writing.** ***PAYMENT IS DUE IN FULL AT TIME OF SERVICE unless a PRIOR arrangement has been made with the billing department*****. I hereby authorize insurance payment directly to Stephen L. Brown, MD Psychiatric Services.** Charges shown by statements are agreed to be correct and reasonable unless protested in writing within thirty days of the initial billing date. In the event legal action should become necessary to collect an unpaid balance due for services rendered to my family, or myself, I/we agree to pay reasonable attorney's fees or court costs. **I also understand I will be responsible for all non-covered services where allowed by law because of a lack of authorization or any other reason for denial. I understand and agree that I am responsible for obtaining all necessary pre-certification requirements from my insurance company; and, regardless of my insurance status, I am ultimately responsible for payment of services rendered by the doctor and/or his associate.** I understand that if I do not show up for my scheduled visit without canceling 24 hours in advance, **I can be held liable for the full charge of the missed appointment.** This applies to ALL patients and is NOT covered by any insurance, including Medicaid or Medicare.

PLEASE NOTE: This office does not honor Medical Advanced Directives

_____ ___/___/___ _____

Signature of patient or Legal guardian ***Date*** ***Printed patient's name or Legal guardian***

Privacy Practice

PATIENT CONFIDENTIALITY: I understand that my information and my medical record will be kept in the utmost confidential manner. Information will be released only with my written authorization or under the Tarasoff Case rule of "DUTY TO WARN". This requires healthcare professionals to warn person(s) of threats by a patient. "Privacy ends when peril to the public begins."

By signing this form, you are granting consent to Dr. Stephen Brown & Associates to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information.

You have the legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notices by stopping by one of our facilities/offices. You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to this consent in writing, except to the extent we have already used or disclosed your protected health information in reliance on your consent.

_____	___/___/___	_____
Signature of patient or Legal guardian	***Date***	***Printed patient's name or Legal guardian***