Desoto Family Counseling
& Pediatric Therapy Center

FINDING SILVER LININGS SINCE 2001

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JANUARY 2024 PATIENT UPDATE FORM

We are glad you have chosen to continue being one of our patients. **PLEASE** complete each section to the best of your ability. We value our patients and want to ensure you are given the **best care possible**.

[PATIENT INFORMATION]

LAST NAME______________________ FIRST NAME ______________________ MI ________

DATE OF BIRTH _______ | ________ | __________ SOCIAL SECURITY # _________ | _________ | __________

GENDER [MALE] [FEMALE] [PREFER NOT TO SAY] ADDRESS ______________________________

CITY ______________________ STATE ______________________ ZIP ______________________

MARITAL STATUS - [SINGLE] [MARRIED] [WIDOWED] [DIVORCED] [SEPARATED] SPOUSE NAME [IF MARRIED] ______________________

EMAIL ADDRESS: ______________________________ CELL # ________ | __________ | __________

MAILING ADDRESS [if different]: ______________________________

[FINANCIALLY RESPONSIBLE PARTY - IF OTHER THAN PATIENT]

RELATIONSHIP TO PATIENT ______________________ DATE OF BIRTH _____ | _____ | ______ SEX [MALE] [FEMALE]

LAST NAME ______________________ FIRST NAME ______________________ MI ___________

SOCIAL SECURITY # ________ | ______ | _________ PHONE # _______ | _______ | _______

[INSURANCE INFORMATION]

PRIMARY ______________________ SECONDARY [IF APPLICABLE] ______________________

PRIMARY ID ______________________ GROUP #_____________ SECONDARY ID __________________GROUP # __________

[SUBSCRIBER INFORMATION - IF OTHER THAN PATIENT]

LAST NAME ______________________ FIRST NAME ______________________ MI ________

DATE OF BIRTH ________ | _________ | __________ SOCIAL SECURITY # __________ | ________ | _________ SEX [MALE] [FEMALE]

ADDRESS ______________________________

CITY ______________________ STATE __________________ ZIP ___________________

RELATIONSHIP TO PATIENT ______________________ CELL # ________ | _______ | ________

[EMERGENCY CONTACT INFORMATION]

NAME ______________________ RELATIONSHIP TO PATIENT ______________________

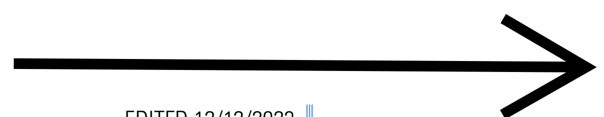
DATE OF BIRTH ________ | _________ | ___________ PHONE # ________ | ________ | ___________

By signing below, I am confirming that all the information I have provided is true to the best of my knowledge.

______________________________ ______________________

PATIENT OR PARENT/LEGAL GUARDIAN SIGNATURE **DATE**

PLEASE TURN OVER



UPDATE OF POLCIES

- **UPDATED POLICIES:** All DFCPTC's policies were reviewed and signed at your/your child's first appointment. The only update to our original policies is the appointment policy.

[APPOINTMENT POLICY]

Our office policy requires ALL appointments needing to be cancelled and/or rescheduled by 1:00 PM the day PRIOR to your appointment. We have this policy set in place so that our providers are given the opportunity to fill in any cancellations that may arise. If a patient cancels and/or reschedules an appointment LATER THAN 1:00 PM the day PRIOR to their appointment – that will be considered a LATE CANCELLATION. If a patient fails to cancel an appointment at all – this will be considered a NO SHOW. We also have a grace-period in which a patient may arrive at the appointment and still be seen. The grace period is as follows:

- Counseling, Occupational, and Physical Therapy has a 20-minute grace period.
- Medication Management has a 10-minute grace period.
- Speech Therapy is based on your scheduled appointment time. Please see your provider for additional information.

If a patient arrives after the grace period, the patient will not be seen by the provider. If a patient consistently arrives to their appointments late but within the grace period, their provider will address this issue with them. Our policy is that if a client accumulates 2 consecutive late cancellations/no shows or 4 total late cancellations/no shows in a 12-month period beginning at the initial appointment, the provider then has the right to refer the patient to another mental health facility and terminate services within Desoto Family Counseling and Pediatric Therapy Center. If a patient ever wants to dispute that an appointment was cancelled within the time stated by our policy, we ask that you address the matter with your provider and in turn the solution can be passed on to our front staff.
If you have read, and agree to, all the terms regarding our appointment cancellation policy please sign below.
If you have read, and agree to, all the terms regarding our updated appointment cancellation policy please sign below.

PATIENT/ GUARDIAN SIGNATURE ____ DATE ____________________

- **ESTABLISHED POLICIES:** Below is a list of the policies that you have already read and signed at the time you began services with us. ***If you would like a printed copy of all our policies from the new patient paperwork that you filled out, we will provide this for you today. Please ask the front desk staff.***

Authorization to release medical information and payment of insurance benefits; financial guidelines; patient communication guidelines; statement to permit payment of Medicare benefits to physicians; technology guidelines; decision to terminate policy; acknowledgment of privacy practices; clients with divorced parents or guardians policy; our Fee Schedule policy; patient communication policy; authorization to release limited information; ethics, client welfare, and safety; communication response time; acknowledge of telemental health policy; confidentiality and records; duty to update insurance information; and release of information for family and or friends of the client.

If you have read and agree to the above list of the established policies, please sign below.

PATIENT/ GUARDIAN SIGNATURE ____ DATE ____________________