**BOOKING CONFIRMATION**

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| --- |
| FIRST NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ LAST NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| DOB: \_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_ | AGE:  |
| MARITAL STATUS:  Single Married Divorced Widowed  | SSN: \_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_ |
| ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| EMAIL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| CELL PHONE: \_\_\_\_\_\_-\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_  |  HOME PHONE: \_\_\_\_\_\_-\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_ |
| BEST WAY TO CONTACT YOU(circle one):  Email Mobile Phone Home Phone  |

**PLEASE CALL AND SCHEDULE AN APPOINTMENT TIME AND DATE BEFORE SUBMITTING THIS FORM**

**YOUR APPOINTMENT IS NOT OFFICIALLY CONFIRMED UNTIL THIS DOCUMENT IS SUBMITTED**

**Office Policies and Procedures**

This is a notice of the policies and procedures of this practice. You have the right to obtain this form for your own records at any time. Please read below and sign in agreeance to the policies and procedures of Garden Psych LLC.

**Prescription Policy**

1. **Keep up to date with your supply of medication**: Patients are asked to track their supply and ensure they have an appointment scheduled before they run out of medication or run out of existing refills. Some patients may find that they become aware of running low on medications only at the last minute, and then have difficulty getting onto the doctor’s schedule. Please be proactive in your care and track how much medication you have and how many refills remain on the prescription, and ensure you have an appointment to see the doctor before you run out of medication.
2. **Requests for Prescription Refill**: If you do need to make a prescription refill request please call our main office number 609-601-4161. Please leave a detailed message including your name, date of birth, name of medication, dosage, and pharmacy number and location. Or you can utilize our website at gardenpsych.com. Please expect a delay of at least 3 business days’ notice for refills. Please contact the pharmacy if you have not received confirmation by 7:00 pm on the 3rd business day. Due to recent changes in NJ drug law, stimulant medication can only be refilled for a maximum of 3 months without a follow up appointment. Refills will not be done over the weekends, holidays or after 3:00 pm on Friday. Please ensure you have enough medication during these times.
3. **Lost or Stolen Prescriptions**: Any lost or stolen prescriptions will not be replaced or rewritten. This includes all benzodiazepines and stimulant drugs. NO EXCEPTIONS. If you miss or cancel an appointment, it is at the providers discretion to write a prescription for enough medication to last only until the next appointment.
4. **Medication Changes**: Medication changes will only be addressed during scheduled appointment times. If you are having side effects or urgent issues with the medication you are taking, please call our office to schedule the next available appointment or office staff can send the doctor a confidential message.
5. **Supply for Controlled Substances**: Prescribers of Garden Psych are unable to provide 90-day prescriptions for controlled substances such as stimulants and benzodiazepines.
6. **Timeframe for Refills**: If it has been 6 months or longer since your last appointment, you WILL need to be seen for a reassessment before medication will be prescribed.
7. **Prior Authorization**: Our office will assist you in obtaining a prior authorization for your medication if needed. You will be responsible for any copayments or deductibles per your insurance contract.

**Financial Policy**

PAYMENTS ARE DUE AT THE TIME OF SERVICE UNLESS PAYMENT ARRANGEMENTS HAVE BEEN REQUESTED AND APPROVED IN ADVANCE. YOU ARE EXPECTED TO PAY ACCORDING TO THE ARRANGEMENT.

* 1. **Insurance**: We do not participate with insurance and are out of network. Many insurance plans have out-of-network benefits. We can provide you a superbill, documenting services and payment, which you can submit to your insurance for reimbursement
	2. **Failure to meet financial obligations**: If you fail to meet your financial obligations in a timely manner, we reserve the right to discontinue care. You are responsible for any interest, agency, and fees associated with collections.

**Appointments Policy**

1. **Cancellations:** A minimum of **2 business days**’ notice must be given when cancelling your appointment to avoid a charge. This will allow us to reach someone on our waiting list and offer him or her the appointment time. Failure to give notice of at least 2 business days for cancellations will result in a charge of the full session. This is due ON OR BEFORE your next appointment. **We realize that emergencies do happen, but this allows us to meet the needs of all of our patients.**
2. **New patients:** For new patient evaluations, we ask you give 48-hour notice for cancelling. If you do not provide 48-hour notice, we may choose to not reschedule your appointment.
3. **Late Arrivals:** If you arrive late your appointment may be cancelled and will need to either reschedule or be seen after other patients. Punctual arrivals will have priority.
4. **Termination of Service:** Multiple late cancellations, no-shows, and other forms of non-compliance with treatment may result in termination of service.
5. **Reminder texts:** As courtesy, we offer reminder texts about your upcoming appointment, typically two business days in advanced. Due to unforeseen circumstances, we are not always able to do so, but please remember that you are ultimately responsible for your scheduled appointments.
6. **Wait policy:** If you are waiting longer than an hour and a half past your scheduled appointment time, please call our of at 609-601-4161 and alert our staff. We know that your time is important to you and we will assist you with needed refills and reschedule you for the next available appointment with your provider. Please be patient as patient emergencies and crises do occur and cannot be accounted for ahead of time.

**Form Completion**

Please allow 14 business days for requested form completions (letters, FMLA, Disabilities, etc.). No patient paperwork will be completed on the first patient visit.

\*\*\*\*\*\*IF YOU ARE EXPERIENCING ACUTE DISTRESS, SELF-HARM OR SUICIDAL THOUGHTS, CALL 911 OR GO TO YOUR NEAREST EMERGENCY ROOM!

**Please sign if you have read through, understand, and agree of all of our office policies and procedures.**

**Parent/Gaudian Signature x\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parent/Gaudian Name x\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Notice of Privacy Practices**

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.
Please review it carefully.

We care about our patients and strive to protect the confidentiality of your medical information at this practice. New federal legislation requires that we issue this official notice of our privacy practices. You have the right to the confidentiality of your medical information, and this practice is required by the law to maintain the privacy of that information.

**How We May Use and Disclose Medical Information About You**

The following categories describe different ways that we may use and disclose medical information without your specific consent or authorization. Examples provided for each category of uses or disclosures. Not all possible uses or disclosures are listed.

We may disclose your medical information for the purposes of treatment, payment and heath care operations.

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

**Disclosure and Changes to Your Medical Information**

**Right to Request Restrictions**: You have the right to request restriction or limitation on the medical information. To request restrictions, you must submit your request in writing. In your request, you must tell us what information you want to limit.

**Changes to This Notice**

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future.

**CONSENT FOR TREATMENT**

The undersigned patient or responsible party (parent, legal guardian or conservator) consents to, and authorizes services, by Dr. Hasan Memon, MD and employees of at Garden Psych and Psychiatronics, LLC. These services may include psychotherapy, medication therapy, laboratory tests, diagnostic procedures and other appropriate alternative therapies.

The undersigned understands that he/she has the right to:

1. Be informed of and participate in the selection of treatment modalities.
2. Receive a copy of this consent.
3. Withdraw this consent at any time.

**I have read, understand and agree to all the statements in this notice. I understand how my medical information may be used and the purpose of its use.**

**Signature x\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parent/Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CREDIT CARD ON FILE AUTHORIZATION FORM**

This form is for you to supply Garden Psych through Psychiatronics LLC. with credit card information to keep on file for the payment of all services and fees. A new form must be completed for each card kept on file. You may elect to provide us with credit card information separately for each payment. We accept all major credit cards for payment.

**Card Information:**

Card Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name on Card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Card Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expiration Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CVV Code (Security Code): \_\_\_\_\_\_\_\_\_\_\_

Billing Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cardholder Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list anyone other than the cardholder that is authorized to use this credit card.**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cardholder Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, (print name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize Psychiatronics LLC to charge the above credit card account for payments owed to my account for services rendered at their office. I agree to update any information regarding this account. The above information is complete and correct to the best of my knowledge.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_