Print Form

Fax forms to 703-573-2351

NOVAPSY
NORTHERN VIRGINIA PSYCHIATRIC GROUP, P.C.

SERVING THE COMMUNITY SINCE 1978

Dear Patient:

PLEASE BE AWARE THIS IS A NEW UPDATE FORM

If you see a psychiatrist – PLEASE MAKE SURE TO INDICATE A PREFERRED PHARMACY as some RX's may be able to be sent electronically to your pharmacy.

Please complete the attached form in its ENTIRETY for any demographic changes to your account: example: change in home, work or cell numbers, change of address, CHANGE IN INSURANCE COVERAGE.

Once the form is completed you can email, fax or mail it to us:

Email: frontdesk@nvpgpc.com

Fax it back to 703-573-2351 Attn: Patient Registration

Mail it back to: Novapsy, 8500 Executive Park Drive, Suite 200, Fairfax, VA 22031

IF REPORTING AN INSURANCE CHANGE – PLEASE MAKE SURE ALL THE SUBSCRIBER INFORMATION IS COMPLETE IN THE INSURANCE SECTION AND **MAKE A COPY OF THE FRONT AND BACK OF YOUR INSURANCE**

Any questions, please call front desk for assistance at 703-698-5220 ext 331

Thank you for your cooperation.

Novapsy

8500 Executive Park Avenue ♦ Suite 200 ♦ Fairfax, Virginia 22031
703.698.5220 ♦ 703.573.2351 (fax)

PATIENT INFORMATION UPDATE

(If you have not been seen in the last 6 months or any information has changed, please fill out)

DATE:_____ **DOCTOR/CLINICIAN SEEING TODAY:**_____

PATIENT :_____ ☐**Male** ☐**Female**
Last **First** **(middle initial)**

SSN#_____ **DOB:**_____**RACE:**____**ETHNICITY**: ☐Non-Hispanic ☐Hispanic
(circle one)

MARITAL STATUS (circle one) : ☐Single ☐Married ☐Divorced ☐Widowed

ADDRESS :_____
 # Street **City** **State** **Zip**

LOCAL PHARMACY NAME /ADDRESS/PHONE _____
(some RX's may be sent electronically to phcy)

HOME #:_____ **WORK #:**_____

CELL#:_____ **PREFERRED # TO CONFIRM APPTS:** ☐**Home** ☐**CELL**

GUARANTOR NAME :_____
(Person responsible for bill)

ADDRESS:_____
Street City State Zip

DOB: _____ **SSN#:**_____

HOME #:_____ **WORK #:**_____

CELL#:_____ **PREFERRED PHONE # TO CALL:**_____

RELATIONSHIP TO PATIENT: ☐**SELF** ☐**SPOUSE** ☐**CHILD** ☐**OTHER**_____

PRIMARY INSURANCE NAME:_____**EFFECT DATE**_____

POLICYHOLDER NAME:_____**DOB**:_____ **SSN**:_____

ADDRESS OF POLICYHOLDER:_____
(if different from patient/guarantor-required for ins):

ID#_____ **GROUP#**_____

RELATIONSHIP TO INSURED: ☐**SELF** ☐**SPOUSE** ☐**CHILD** ☐**OTHER**_____

SECONDARY INSURANCE NAME:_____**EFFECT DATE:** _____

POLICYHOLDER NAME:_____**DOB**:_____ **SSN**:_____

ADDRESS OF POLICYHOLDER:_____
(if different from patient/guarantor-required for ins):

ID#_____ **GROUP#**_____

RELATIONSHIP TO INSURED: ☐**SELF** ☐**SPOUSE** ☐**CHILD** ☐**OTHER**_____

PLEASE SIGN THE SECOND PAGE

Authorization for Assignment of Benefits / Release of Information/ Financial Agreement

I authorize the Northern Virginia Psychiatric Group (NoVaPsy) to apply for benefits from my insurance carrier and further authorize payment directly to NoVaPsy for the medical and/or mental health benefits, if any, otherwise payable to me for services rendered by NoVaPsy. I understand that this service is available for health plans that NoVaPsy participates and will only be submitted for the primary insurance plan unless my primary plan is Medicare. I further authorize the release of medical/mental health information required by my insurance carrier or its designated review agent, required for payment, or (if applicable) my employer's worker's compensation insurance carrier in order to determine benefits to which I may be entitled, or to designated agents of NoVaPsy. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me or by the insurance carrier at any time in writing. I hereby assume financial responsibility for and agree to make payment in full to NoVaPsy for all charges for services provided to the above-named patient not otherwise authorized or paid by my insurance carrier**. Payment is to be made within fourteen (14) days as statements are presented with settlement in full, or payment arrangements to be made with NoVaPsy. I certify that the information given is true, accurate, and complete to the best of my knowledge, and further authorize NoVaPsy to investigate any and all information given concerning this or related claims**

Policies and Procedures

PRESCRIPTION REFILLS: Refills not made during scheduled visits may be requested via email, fax, or phone. If you choose to utilize our prescription refill service, **you will be charged an administrative fee of $25** that will not be billed to or reimbursed by your insurance carrier. Please refer to handout Medication Refills without a Visit for instructions.

LATE CANCELLATIONS/ MISSED APPOINTMENTS POLICY:

If you cancel your appointment without 24 (twenty-four) hour notice, or do not show for a scheduled appointment, your PhD/LCSW will charge you $100 per session. MD's charge 15 min=$65 appts/ 30min or longer = $130 per session. To avoid this charge, you must leave your clinician a message in their voice mail the preceding workday. All decisions concerning charges are made at the discretion of the clinicians. Our voice mail system records date and time of your call. Work-related cancellations are not excused cancellations and you will incur a charge.

FEES:

At the time of your visit, we will be glad to discuss our fee structure for specific diagnostic/treatment procedures. Please direct these questions to your clinician. You will be expected to pay your deductible and/or co-payment at the time of each visit. We will bill your primary insurance carrier if you have signed the authorization section below and if we participate with health plan.

RETURNED CHECKS:

There is a $25 (Twenty-five) charge for any returned check from your bank.

INSURANCE COVERAGE:

Insurance companies and employer plans vary significantly in how they administer mental health benefits. We strongly urge you to know what deductibles, co-payments, visit and/or benefit limitations, authorization requirements, and exclusions your plan may include. If we have submitted a claim to your carrier, we will receive an Explanation of Benefits (EOB) from the plan. NoVaPsy will use this information to determine your responsibility for full payment. You should review the EOB that is sent to you by the plan carefully. If you feel that they have made in error in administering your benefits, please call them directly to have it corrected. We will use the EOB as a final determination of benefits available.

NOTIFICATION OF CHANGES:

We expect that you will notify our office immediately of changes in the following information:

- **Name, address, or phone number changes**
- **Change in Insurance Carrier**
- **Change in Primary Care Physician**
- **Change in marital status**

I understand and agree to abide by the above policies and procedures:

RESPONSIBLE PARTY SIGNATURE: _____ **DATE:** _____

PLEASE REMEMBER TO SIGN