228 W 2nd Street
Muscatine, IA 52761
Phone: 563-278-2796
Fax: 563-513-0385

PATIENT INFORMATION

LAST NAME: _____ FIRST NAME: _____ MIDDLE INITIAL:____
DOB: _____ GENDER: _____ETHNICITY: _____
ADDRESS: _____ APARTMENT NO: _____
CITY: _____ STATE: _____ ZIP: _____
PHONE NUMBER: _____ PREFER (circle): VOICEMAIL, TEXT, EMAIL
EMAIL: _____
EMPLOYER: _____ OCCUPATION: _____
SCHOOL ATTENDING: _____ GRADE: _____
PRIMARY CARE PROVIDER: _____ PHONE: _____
DO YOU WANT RECORDS RELEASED TO PRIMARY CARE PROVIDER (circle): YES, NO
PARENTS/GUARDIAN (IF MINOR): _____
EMERGENCY CONTACT: _____ PHONE: _____

POLICY AGREEMENT

- I understand Pearl City Psychiatry does not collect co-pays at time of service. I will be billed for any co-pays and agree to have balance paid within 30 days. I understand that if the balance is not paid within 90 days the balance will be turned over to collection agency and may result in discharge from the practice. _____
  Initial

- I understand three missed visits (which include canceled appointments without 24-hour cancelation notice) will result in discharge from the practice. _____
  Initial

- I understand Pearl City Psychiatry has inadequate services to cover emergency care. I agree to contact 911 or go to ER with medical or psychiatric emergencies. _____
  Initial

- I understand records are kept under the strictest rules of confidentiality which means that information about your treatment will not be released to any outside individual without written consent. However, I understand that rules of confidentiality will be broken under certain circumstances if I am a danger to myself or others. _____
  Initial

CONSENT

I have read the above policy agreement and consent to services provided by Pearl City Psychiatry, PLLC.

_____
Signature