

Mark G. Agresti, M.D. and Associates is a multi disciplinary psychiatric practice made up of caring professionals who strive to provide top quality service based on the individual needs of our patients. To aid us in this goal, we ask that you read and familiarize yourself with the following.

### **HOURS OF OPERATION:**

Support staff is available to answer the phones in the office from 10:00am to 6:00pm Monday through Friday. After these hours, our answering service will handle phone calls and Dr. Agresti or your clinician will be paged for emergencies only. We are also available by email: [AGRESTIMD@yahoo.com](mailto:AGRESTIMD@yahoo.com). The email is checked daily.

### **APPOINTMENTS AND CANCELLATIONS:**

Appointments need to be scheduled in advance and this time is set-aside for you. Same day cancellations and missed appointments make it difficult to schedule someone else in that time slot. **If you have to cancel an appointment, you must give at least 24 hours notice. Late cancellations and missed appointments will be charged a \$65.00 fee for which you, not your insurance company will be responsible.**

After two consecutive missed appointments you must get approval from your provider before being rescheduled.

### **PRESCRIPTION REFILLS:**

When you are in need of a prescription refill you should call **at least two days in advance**. Periodic appointments for medication management are required to assess your progress and allow you to continue to receive refills.

### **FEES AND CO-PAYMENTS:**

Fees are expected to be paid at the time of service. We accept cash, credit and debit cards money orders and personal checks. No business checks are accepted. If you do not have your copay or payment, we will have to reschedule your appointment.

### **AUTHORIZATIONS:**

Most insurances require prior authorization before your visit and a separate authorization is required for each provider you see in this office. It is the responsibility of the patient to obtain the first authorization. Any additional authorizations will be obtained by the office.

### **PERSONAL INFORMATION:**

It is extremely important to keep this office updated on any changes in personal information such as address, phone numbers, and insurances.

## **FEES FOR COPIES OF MEDICAL RECORDS, FORMS, AND LETTERS:**

If you request a copy of your medical records to be sent out of this office a release needs to be signed and there is a \$1.00 charge per page to copy it. This also applies to releases signed by yourself releasing your medical records to insurance companies or attorneys. You will not be charged if your medical records are transferred directly to another physician's office.

If you request a basic one page letter or form to be filled out from your provider there is a minimum fee of \$35.00.

Detailed forms and reports take more time so there will be an additional cost and a rate will be quoted to you.

**CONFIDENTIALITY:**

Confidentiality is protected by both state and federal laws. We adhere strictly to these laws and will not disclose any clinical information without a signed release of information from you. The exception to this would be in cases where there is clear and immediate danger to you, someone else or in cases of abuse, then appropriate action will be taken.

Patients should mail concerns, complaints or suggestions to:

Dr. Mark Agresti (Confidential)  
2010 Continental Drive  
West Palm Beach, Fl. 33407

By signing this page, it will be a consent for treatment at the office of Dr Mark Agresti and associates and also acknowledges that the rules of this practice have been read. In addition I hereby give consent for Mark Agresti and Associates to use or disclose private health information, including records, for purposes of treatment and/or payment.

Signature of Patient\_\_\_\_\_ Date\_\_\_\_\_

Signature of Parent/Guardian\_\_\_\_\_ Date\_\_\_\_\_



**PATIENT INFORMATION:**  
***Please print clearly***

Patient Name:

\_\_\_\_\_

First	Middle Initial	Last
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Address: \_\_\_\_\_

Street	Apt#	City	State	Zip code
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Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ S.S.#: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

Marital Status:      S   M   D   W   Sep   Other (circle one please)

**Referred by:**

\_\_\_\_\_

(physician, family, friend, phonebook, internet, insurance, etc..)

Employment/School: \_\_\_\_\_

Name	Address
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Occupation: \_\_\_\_\_ Work Phone #: \_\_\_\_\_ Ext #: \_\_\_\_\_

Spouse/Patient/Legal Guardian: \_\_\_\_\_ S.S.# \_\_\_\_\_

Address (if different from above): \_\_\_\_\_

Employer: \_\_\_\_\_

Name	Address
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Name of the insured: \_\_\_\_\_ D.O.B.: \_\_\_\_\_ Relationship: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group#: \_\_\_\_\_

Authorization #: \_\_\_\_\_ EAP Company: \_\_\_\_\_

I understand that, unless I am covered by a prepaid medical plan in which the physician or therapist participates, I am expected to pay for services at the time they are rendered. All copayment, deductibles and coinsurance amounts are due at the time of service. **If I am unable to keep an appointment, I agree to pay the charge for the time reserved unless I give notice of cancellation at least 24hrs. prior to the**

**scheduled appointment.** If at any time my account should become delinquent, I understand that I am responsible for payment of any fees incurred in the collection process. I authorize payment of all medical benefits to Mark Agresti MD, P.A. for services rendered in this office.

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

Note: All information given by you or your family is treated as confidential, and may be released only upon your consent, as required by law.

**Communication Release Form:**

I hereby give permission to Dr. Agresti's office staff to leave messages by telephone or by email for the following reasons:

Appointment reminder, either by personal message, recorded message, or email.

Yes \_\_\_\_\_ No \_\_\_\_\_

To leave a message or email to call the office regarding appointments, prescription or other information.

Yes \_\_\_\_\_ No \_\_\_\_\_

I also give permission to the individuals listed below to receive the information on my behalf:

\_\_\_\_\_  
\_\_\_\_\_

I understand this form is intended to guard my privacy and is not a release of general information.

\_\_\_\_\_  
Patient Signature Date

**EMERGENCY CONTACT**

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

Address: \_\_\_\_\_

Home #: \_\_\_\_\_ Cell#: \_\_\_\_\_

Work#: \_\_\_\_\_ Ext: \_\_\_\_\_

**INSURANCE WAIVER:**

Please be advised that all services we provide for you in our office will be billed to your insurance company if we are contracted with your plan. You may become the liable party should your insurance company fail to pay us for the service.

We expect you to pay all deductibles and co-pays at time of service. If you have no insurance, payment in full is expected at time of service. Also, please be aware of what is covered and what is not covered under your particular insurance plan. **We do not pre-verify benefits for all of our patients and/or diagnostic services.** If there is a service that is not covered by your insurance company, you will become the liable party should your insurance company not pay.

Due to ever growing and changing insurance markets, we are unable to verify if we are participating with your insurance company. It will be left up to you to pre-verify that we are participating with your insurance company or their networks. If we do not participate with your insurance company, you will be responsible to pay for the service being rendered at the time of service, although we will provide "Courtesy Billing" for you. Any one knowingly (intentionally) providing false information or not updating information may be discharged from the practice and the account will be turned over to collections.

I am signing that I have read, accept and understand the above insurance waiver for all my services.

Patient Name (print) (If under the age of 18, parent or legal guardian must sign)	Signature	Date
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**HIPAA**

I hereby acknowledge that I have been given an opportunity to read a copy of Mark Agresti and Associate's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Gary Marmon at 2010 Continental Drive, West Palm Beach, Florida 33407.

Signature of Patient/Client	Date
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Signature or Parent, Guardian or Personal Representative *	Date
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**DID NOT KEEP APPOINTMENTS:**

The office policy is that “no shows” or cancellations of less than 24 hours will be charged a fee of \$65.00 per appointment to cover the time lost. This fee is the responsibility of the patient and cannot be billed to your insurance company. This policy will not include sudden serious emergencies that arise when you call and inform us.

- Reminder phone calls are made to our patients 1-2 days before a scheduled appointment. These phone calls are extended as a courtesy on our part but it is your responsibility as the patient to remember to attend your scheduled appointments. Not receiving a reminder call does not constitute a valid excuse for missing an appointment so you will be charged as per the policy above.

I have read and accept the above policy.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent, Legal guardian, etc...

\_\_\_\_\_  
Date



Birthdate: \_\_\_\_\_  
(mm/dd/yyyy)

Name of PCP/Medical physician: \_\_\_\_\_

PCP/Medical physician phone: ( ) \_\_\_\_\_ fax: ( ) \_\_\_\_\_

\_\_\_\_ Check here if no primary or medical physician

**Patient Authorization-** (Only need to sign at initial and yearly update)

I, the undersigned, understand that I may revoke this consent at any time except to the extent that the action has been taken in reliance upon it and that in any event, this consent shall expire one year from the date of the signature, unless another date is specified. I have read and understand the above information and give my authorization.

Please Check One:

\_\_\_\_ To release any applicable mental health/substance abuse information to my primary care and/or medical physician.

\_\_\_\_ I do not give my authorization to release information to my primary care and/or medical physician.

Patient Signature: \_\_\_\_\_  
Date

***Below is to be completed by Dr. Mark Agresti and Associates***

The above patient has been evaluated in this office and a treatment plan developed. To improve continuity of care, your patient has consented to share information with you.

\_\_\_\_\_Initial contact      \_\_\_\_\_Updated      Date:\_\_\_\_\_

Mental Health Provider(s): \_\_\_\_\_

Presenting Problem/Clinical Information: \_\_\_\_\_

Medications:

In order to provide the best quality care for our patients, Dr. Agresti and Associates are now using the CarePrescribe system. This enables our office to send prescriptions and authorize renewals directly to your pharmacy electronically. CarePrescribe eliminates calls to pharmacies, hold time on the telephone, callbacks and faxing to pharmacies. This tool provides medication history and coverage, along with drug-to-drug interaction to ensure your safety. Medications that are controlled (Stimulants, Amphetamines, sleep medications etc...) are unable to be processed by this system at this time.

Sign and print below to authorize Dr. Agresti and Associates to use the CarePrescribe system.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print name

If you ***do not authorize*** Dr. Agresti and Associates to use CarePrescribe, please sign below:

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date