GERALD D. CHITTERS M.D.
PSYCHIATRIST

Please return to:
Phone: 303.545.5380 Fax: 303.402.0445
email: meredith@gdchittersmd.com

Please complete both sides and fax or e-mail the billing office

PATIENT INFORMATION

☐ NEW PATIENT ☐ UPDATE

Patient Name _____ **Date of Birth** _____

Street Address _____ **Insured DOB** _____

City, State, Zip Code _____ **Insured Name** _____

Phone: (h) _____ **Relationship to patient** _____

(w _____ **Insured Employer** _____

(c _____ **Diagnosis** _____

Email Address _____

Insurance Company _____ **Phone #** _____

Subscriber # _____ **Group #** _____

How did you hear about us? Please provide referral name and phone number :

_____

Who may we contact in case of emergency? Contact name _____ **Phone #** ___

AUTHORIZATION TO RELEASE INFORMATION

I authorize the release of the above provided information and any medical information necessary to: 1) provide for adequate professional coverage in the absence of the primary doctor, 2) to verify insurance coverage and 3) to file a claim for insurance benefits related to professional services rendered.

Patient Signature _____ **Date** _____

Responsible Party _____ **Date** _____

Therapist Name: _____ **Phone:** _____

Primary Care Physician Name: _____ **Phone:** _____

Address: _____

I hereby give my permission to contact the above therapist and/or doctor to coordinate care:

☐yes ☐ no _____ _____

Signature **Date**

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AUTHORIZATION OF ASSIGNMENT OF BENEFITS

I authorize direct payment of insurance benefits from _____ to Gerald D. Chitters, MD for professional services rendered.
Insurance Company

Patient Signature _____ Date _____

Responsible Party Information if different than patient:

Responsible Party's Name

Street Address **City** **State** **Zip Code**

Home Phone **Work Phone** **Employer**

PAYMENT INFORMATION
If the patient is a minor all billing will be the full financial responsibility of the parent the child resides with. Please make your own arrangements to receive any reimbursements from other parties.

A missed session will be charged at the regular rate if it is not cancelled 48 hours before the appointment. You will not be charged if we fill the time slot from the wait list. Monday appointments must be cancelled by 12 noon the Friday before.

INSURANCE INFORMATION
Please be advised that some medical diagnoses may affect your ability to get health and/or life insurance in the future. If an insurance company will be paying us directly or reimbursing you for your doctor visits you must call them before your first appointment with Dr. Chitters to verify prior authorization requirements. In addition, please call our billing office at 303.487.4990 to give them the information necessary to bill the insurance company for your visits. Failure to do so may result in you being financially responsible for your sessions.

PLEASE PROVIDE YOUR INSURANCE CARD FOR US TO COPY.

FOR OFFICE USE ONLY

In Network **Parity** **Out of Network** **Contact/Date: _____**

DEDUCTIBLE _____

DEDUCT MET _____ AS OF DATE _____ OUT OF POCKET MAX _____

CLAIMS MAILING ADDRESS: _____

INSURANCE PAYS _____ _____ _____ _____

COPAY/COINSURANCE _____ _____ _____ _____

YEAR MAXIMUM _____ _____ Payer # _____

LIFETIME MAXIMUM _____ _____ Ptn Notified _____

NETWORK_____ _____IN ____ OUT Dr. Notified _____

Precertification/Ongoing Cert Required?_____ YES _____ NO

MCO Name _____ Phone # _____ Contact_____

Authorization # _____ # of Visits Auth'd_____ Date Range _____ CPT Code _____ Notes_____

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MEDICAL INFORMATION

Psychiatric: Relevant medical conditions [history, current condition, changes in condition]:

Medications [dosage, dates of initial prescriptions, name of prescribing professional]:

Allergies/adverse reactions to treatment:

Medical: Relevant medical conditions [history, current condition, changes in condition]:

Medications [dosage, dates of initial prescriptions, name of prescribing professional]:

Allergies/adverse reactions to treatment:

954 North Street, Suite #302, Boulder CO 80304 ■ tel: 303.545.5380 ■ fax: 303.402.0445

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CANCELLATION POLICY
NOTICE: EFFECTIVE January 1, 2015

Our policy is that we require a <u>minimum</u> of 48 hours notice to try to fill your time slot if you must cancel. Monday appointments must be cancelled by Thursday morning. Late cancellations and no-shows for ½ hour sessions will be charged $100.00, $170 for one hour sessions. Insurance does not pay for these. Please allow yourself enough <u>extra</u> time to get to your session on time, considering traffic accidents, construction delays, and bad weather. Thank you for your consideration of the doctor's time.

Signature

Date

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