Cary Psychiatry 2023 Patient Information Update Form

Cary Psychiatry would like to thank you for working with us to improve your mental health care. Our family of providers and staff are here for you and appreciate the time you take to keep your information up to date with our practice. *Why is this important?* Insurance companies rely on accurate information not only to process office visit claims, but also to verify prescription authorizations. Additionally, addresses and phone numbers are a method that pharmacies and pharmacy benefits use to identify patients for medication pick-ups and must be kept accurate and current. This includes patient safety.

ALL PATIENTS ARE REQUIRED TO COMPLETE AND RETURN THIS FORM ENTIRELY WITH A PHOTO OF ACTIVE 2023 INSURANCE PRIOR TO THEIR FIRST APPOINTMENT OF 2023

Failure to do so will delay prescription refills and/or result in the self-pay cost for appointments

Fax Form & Insurance to: 919-234-0494 OR Email Form & insurance to: Admin@CaryPsychiatryCenter.com

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Demographics

Patient Name: _____ Date of Birth: _____ Preferred Name: _____

Biological Sex: _____ Gender Preference: _____ E-Mail: _____

Phone Number Primary: _____ Secondary: _____

Home Address: _____ City _____ State _____ Zip _____

Information above must match what is on file with BCBS

Notification preferences for Appointment Reminders

Please select at least TWO of the following: Phone Call Text Message (SMS) Email

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Insurance

Insurance provided must be Blue Cross Blue Shield only, active after 01/01/2023. Cary Psychiatry will no longer file Cigna or United Healthcare. We are not in-network with BlueHome, Blue Value, or Medicaid/Medicare. If you have another insurance plan outside of these, you will be considered self-pay with our office. The self-pay rates for 2023 are $200 for follow-up appointments.

SELF PAY check here: ☐

Insurance Carrier: Blue Cross Blue Shield

Insurance Subscriber or Member ID: _____

Insurance Group Number: _____

Credit Card on File

At Cary Psychiatry, we require patients to keep a credit or debit card on file for the estimated patient responsibility for the appointment. These can be services that the insurance does not cover, for which you are liable. Your information is kept confidential and secure. Card payments are processed based on the information that our office can confirm with the insurance company. In completing the information below, you agree to the following statement:

I authorize Cary Psychiatry to charge the portion of my bill that is my financial responsibility to the following credit or debit card.

I (we), the electronically undersigned, authorize Cary Psychiatry to charge my credit card, indicated below, for balances due for services rendered that my insurance company identifies as my financial responsibility. This authorization relates to all payments not covered by my insurance company for services provided to me by Cary Psychiatry. This Authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 60-day notification to Cary Psychiatry in writing and my patient financial account must be in good standing.

Cardholder Name: _____ Cardholder Phone Number: _____

Billing Zip Code: _____ Card Number: _____ Expiration Date: _____ CVV: _____

Patient Signature (First name, Last name): _____ Date: _____

Thank you for choosing Cary Psychiatry to be a part of your healthcare team.