

Spring Child & Adult Psychiatry

Xiaohong Hu, M.D., M.S., Haiwang Tang, M.D., Ph.D.

Suite #107
11032 Quail Creek Road
Oklahoma City, OK 73120

Phone: (405) 608-4122
Fax: (405) 608-2210

INITIAL INTAKE FORM

PATIENT'S INFO:

FIRST NAME:	LAST NAME:	SEX:
DOB:	AGE:	SSN:
ADDRESS:		
CITY:	STATE:	ZIP CODE:
HOME PHONE:	CELL PHONE:	WORK PHONE:
PRIMARY INSURANCE:	INSURANCE POLICY NUMBER:	
SECONDARY INSURANCE:	INSURANCE POLICY NUMBER:	

EMERGENCY CONTACT PERSON INFO:

FIRST NAME:	LAST NAME:	Sex:
ADDRESS:		
CITY:	STATE:	ZIP CODE:
HOME PHONE:	CELL PHONE:	WORK PHONE:

INSURANCE SUBSCRIBER'S INFO:

FIRST NAME:	LAST NAME:	SEX:
DOB:	AGE:	SSN:
ADDRESS:		
CITY:	STATE:	ZIP CODE:
HOME PHONE:	CELL PHONE:	WORK PHONE:

PAST HEALTH CARER INFO:

PRIMARY CARE PHYSICIAN:	TELEPHONE:
PREVIOUS PSYCHIATRIST:	TELEPHONE:
REFERRED BY:	TELEPHONE:

PARENTS OR GUARDIANS INFO (IF PATIENT IS MINOR):

FATHER NAME:

ADDRESS:	DOB:
CITY:	PHONE:
HOME PHONE:	ZIP CODE:
	SSN:

MOTHER NAME:

ADDRESS:	DOB:
CITY:	PHONE:
HOME PHONE:	ZIP CODE:
	SSN:

LEGAL GARDIAN NAME:

ADDRESS:	DOB:
CITY:	PHONE:
HOME PHONE:	ZIP CODE:
	SSN:

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OFFICE POLICIES

APPOINTMENTS: Patients are seen by appointments only. Per the patients' agreement with their insurance company, co-pay is due at the time of service. Current balances due will be collected at the time of your appointment unless prior arrangements have been made.

NO SHOW OR LATE CANCELLATION: Patients are responsible for a "missed appointment" charge of \$50 if notice of intent to cancel is not provided at least 24 hours before the scheduled appointment. This charge will not be billed to any health plan. In extenuating circumstances, the charge may be waived (e.g., illness, emergencies, weather conditions).

LATE ARRIVALS: Out of courtesy to all our patients, we ask that you be on time to your scheduled appointment. If you are going to be more than 10 minutes late, please call our office to see if we can make any adjustments to the doctor's schedule. In some cases, it may be necessary to reschedule your appointment. If you arrive more than 10 minutes late without calling ahead, the receptionist may have to reschedule your appointment for another time because of the doctor's prior scheduled appointments or obligations.

We are not always able to remind every patient of his or her appointment. It is the patient's responsibility to arrive for their appointment on time. If patient fails to show up without rescheduling and/or cancelling, the doctor will follow up with patient for medication refills at the next available appointment.

DISMISSAL: We reserve the right to review any active patient status and the right to dismiss any patient from our practice after:

- Repeated failure to keep appointments, or frequent no shows
- Noncompliance (not following physician instructions about important health issues)
- Abusive behavior to staff
- Failure to pay your bill

PAYMENT/BILLING: Payment in full is required at the time of service. Insurance will be filed and any balance not paid by insurance will be due by the patient at their next appointment.

FORMS COMPLETION: there may be a fee for completing lengthy or complex forms. It is unlikely that Dr. Hu / Dr. Tang will be able to complete the form while you wait. Forms may be mailed, dropped off or faxed to the office and you will be contacted when it is completed.

I read and understand these policies.

_____ Date _____
Patient signature

_____ Date _____
Parent/legal guardian

_____ Date _____
Witness

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CONSENT FOR TREATMENT

The undersigned patient or responsible party (parent, legal guardian or conservator) consents to, and authorizes services, by Xiaohong Hu, M.D. / Haiwang Tang, M.D. These services may include psychotherapy, medication therapy, laboratory tests, diagnostic procedures and other appropriate alternative therapies.

The undersigned authorizes release of medical or other information to insurance companies necessary to process the claims and to pay any benefits.

The undersigned authorizes payment of benefits to the provider for services provided.

The undersigned understands that he/she has the right to:

1. Be informed of and participate in the selection of treatment modalities.
2. Receive a copy of this consent.
3. Withdraw this consent at any time.

Signature of Patient

Date Signed

Signature of Parent, Legal Guardian or Conservator

Date Signed

Signature of Witness (if appropriate)

Date Signed