Christopher Kye, MD, PA

American Board of Psychiatry & Neurology
Diplomate in Child & Adult Psychiatry

900 NW 17th Ave, Suite 201
Delray Beach, FL 33445
561.501.5761

PATIENT INFORMATION

Today's date: _____

Patient's name : _____

Date of birth: _____ Sex: _____

Current street address: _____

City, State ZIP: _____

Cell phone : _____

Alternate phone: _____

Email address: _____

Referred by: _____

Relationship to patient: _____

CURRENT PRESCRIPTION MEDICATIONS (name, dosage, how long you have taken)

_____

_____

_____

DRUG ALLERGIES

_____

_____

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EMERGENCY CONTACTS (please provide two)

Name: _____

Relationship to patient: _____

Phone number: _____

Name: _____

Relationship to patient: _____

Phone number: _____

BILLING (if different than patient)

Responsible party's name: _____

Street address: _____

City, State ZIP: _____

Phone: _____

INSURANCE

Name of insurance carrier: _____

Primary name _____

RxBin _____

We do not accept insurance. This is for pharmacy and laboratory purposes only. Any insurance claims are the sole responsibility of the patient.

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PERSONAL & FAMILY HISTORY

Check any that apply:	Self	Family	If family member, please specify:
No significant medical history			
Attention deficit disorder			
Autism			
Depression			
Epilepsy			
Mania			
Obsessional thinking			
Panic attacks			
Psychiatric hospitalization			
Psychotic episodes			
Self injurious behavior			
Substance abuse or dependence			
Suicide attempts			
Trauma			

Primary care physician: _____

Current or most recent psychiatrist: _____

Medical specialist(s)
(name and specialty): _____

_____

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OFFICE POLICY AND PROCEDURES

_____ **(Initial)**

FINANCIAL RESPONSIBILITY

Initial evaluation: 90 minutes; Follow-up: 30 minutes
Extended phone time is subject to a fee.

We do not accept cash or checks. Debit and credit cards only

Prepayment fee: The first half of the appointment fee is required to book an appointment. The second half is due at the time of service.

We require patients to schedule their next follow-up at the conclusion of the session.

_____ **(Initial)**

CANCELLATION POLICY

The time frame for cancellations (excluding U.S. federal holidays:)

Initial evaluation (less than 7 business days) - half charge
Follow-up: (less than 3 business days) - half charge
Same day cancellations: (less than 24 hours) - full charge

Continually missing appointments may ultimately lead to termination of the physician-patient relationship.

REFILL POLICY

_____ **(Initial)**

Most prescriptions are written so that you will not run out of medication before the next appointment. **Check for any remaining refills by calling your pharmacy before contacting the office.**

The processing time for refill requests is **two** business days. Please notify the office in advance so that you do not run out of medication.

Contact the office for prescription requests. We do not accept requests from third parties.

_____ _____

Signature of patient or personal representative Date

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REQUEST TO USE ELECTRONIC COMMUNICATION

Information shared over the phone or internet is not encrypted and therefore, inherently insecure. There is no assurance of confidentiality when information is communicated this way. Nevertheless, you may request that we communicate with you via email and text. To do so, you must complete this form.

Patient name: _____ Date of birth: _____

If other than patient, please specify name and relationship: _____

Mobile phone number(s) for electronic communication: _____

Email address(es) for electronic communication: _____

_____ **(Initial)** I certify the email address and cell phone number provided on this request are accurate and I, or the designee on my behalf, accept full responsibility for messages sent to or from this address.

_____ **(Initial)** I understand and acknowledge that email and text communications are not encrypted and are inherently insecure. There is no assurance of confidentiality of information when communicating this way, but I accept the risks outlined in this consent.

_____ **(Initial)** I agree to hold Dr. Christopher Kye harmless from any and all claims and liabilities arising from or related to this request to communicate via email and/or text.

_____ _____

Signature of patient or personal representative Date

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CONTACT INFORMATION

Email:	ckyemd@mac.com	Email is preferred for non-urgent questions and requests.
Office:	561-501-5761	If you reach our voicemail, please leave your name, number, and reason for calling.
After hours phone:	561-512-1245	Clinical emergencies that cannot wait until the next office day only

Please call 911 in the event of an emergency

ACKNOWLEDGMENT

By signing below I acknowledge that I have read this document in entirety and understand the policies explained therein. I agree to abide by these terms during our professional relationship and understand that a failure to do so may result in termination of said relationship.

I am responsible for all fees owed to Dr. Kye at the time of service. I agree to pay the cancellation fee for late cancellations, amounting to half of the regular hourly rate up to the full amount. If the account is not paid when due, reasonable collection and court costs will be paid by me or the responsible party. An interest rate of 1% per month will be charged on any balance.

_____ _____

Signature of patient or parent/guardian Date

_____ _____

Print name Relationship