Welcome to Bien Être Psychiatry

Dear Patient and Family,

Thank you for choosing Bien Être Psychiatry. We look forward to working with you and helping you achieve your mental health and wellness goals. To help make your first visit as productive as possible, please follow the steps below:

Step 1: Complete the Preliminary Intake Forms

Please complete the initial intake forms to provide us with your basic demographic, contact, and administrative information. Once these forms have been received, you are ready to schedule your evaluation.

Step 2: Schedule Your Appointment

Please call our office at **(631) 467-0867** to schedule your initial psychiatric evaluation with **Barbara**, our office manager. She will be happy to assist you with finding a convenient appointment time and answer any questions about the scheduling process.

Step 3: Complete the Clinical Questionnaires

It is strongly recommended that you complete the **Life History Questionnaire** before your first appointment. This questionnaire provides valuable information regarding your symptoms, personal history, family history, educational background, and previous treatment. Completing it in advance allows **Dr. Marie Surpris** to review your information beforehand and make the most of your evaluation time.

Additional questionnaires may be provided in the future, depending on your clinical presentation and treatment needs.

If you have any questions while completing the forms, please don't hesitate to contact our office. We're always happy to help.

We look forward to meeting you and partnering with you on your journey toward improved mental health and well-being.

Warm regards,

Marie Surpris, D.O.
Bien Être Psychiatry
Child, Adolescent & Adult Psychiatry
Virtual Psychiatric Care Throughout New York State
Office: (631) 467-0867

INTAKE PACKET

Please take a few minutes to read these two forms before scheduling your appointment.

After completing and submitting these forms, please contact Barbara, Office Manager, at office **telephone 631-467-0867** or email **barb.surpris@gmail.com** to schedule your appointment.

Completed forms may be emailed to: barb.surpris@gmail.com

APPOINTMENT REMINDER CONSENT

Reminder messages are provided as a courtesy. Patients remain responsible for attending appointments and providing at least 24 hours notice for cancellations.

Cell Phone: _____

Email Address: _____

PATIENT INFORMATION

Patient Name: _____

Date of Birth: _____ Age: _____

Parent/Guardian (if applicable): _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Emergency Contact: _____

Relationship: _____

Emergency Phone: _____

INSURANCE INFORMATION

Insurance Company: _____

Member ID #: _____

BIN #: _____

PCN #: _____

Group#_____

PHARMACY INFORMATION

Pharmacy Name: _____

Pharmacy Phone: _____

Pharmacy Address: _____ ZIP_____

TELEHEALTH CONSENT

☐ I understand tele-health appointments are conducted through secure HIPAA-compliant technology.

☐ I understand technical interruptions may occasionally occur.

☐ I consent to participate in telehealth treatment.

OFFICE POLICIES

Appointments:
Initial evaluations are 1hour appointments.

Follow-up appointments are generally 30 minutes.

Cancellations:
Please provide at least 24 hours notice.

Medication Refills:
Refill requests may require a follow-up appointment.

Payments:
Payment is due at the time of service.

Missed Appointments:
Missed appointments reduce availability for other patients and interrupt continuity of care.
Missed or last minute cancellations may be **charged in full.**

I have read and understand the above policies.

Signature: _____

Date: _____

CREDIT CARD AUTHORIZATION

Thank you for choosing Bien Être Psychiatry.

To simplify payment and help ensure a smooth experience, our office securely maintains a credit or debit card on file for each patient. Cards are charged only in accordance with our office policies with the **standard 4% credit card fee.**

Patient Name: _____ **Date of Birth:** _____

Phone_____**Email**_____

Address_____

Name on Card: _____

Card Type:

◯Visa ◯Mastercard ◯American Express ◯Discover

Card Number: _____Expiration Date: _____

Security Code (CVV): _____ **Billing ZIP Code:** _____

Authorization

I authorize **Marie Surpris, D.O.** to securely maintain this payment method on file for my account. I understand this card may be used for: Telehealth appointments, Missed appointment or late cancellation fees and Outstanding balances authorized by me.

I understand my payment information will be stored securely and handled confidentially in accordance with applicable privacy and security standards.

This authorization will remain in effect until I notify the office in writing that I wish to remove or replace this payment method. Removal of a card on file may require another approved payment method before future appointments can be scheduled.

A receipt is available upon request.

I certify that I am the authorized cardholder and that the information provided above is accurate. I authorize Bien Être Psychiatry to process charges as outlined above.

Cardholder Signature _____

Printed Name:_____

Date:_____