

Welcome to Bien Être Psychiatry

Dear Patient and Family,

Thank you for choosing Bien Être Psychiatry. We look forward to partnering with you to understand your concerns, clarify your needs, and support your mental health and wellness goals.

OUR SERVICES

Bien Être Psychiatry provides comprehensive psychiatric evaluations and expert treatment recommendations for children, adolescents, college-age young adults, and adults. Services include diagnostic clarification, medication consultation and management, second-opinion consultations, and evaluations supporting appropriate school, college, workplace, or disability accommodations. Care is provided virtually throughout New York State.

THREE STEPS BEFORE YOUR FIRST APPOINTMENT

- 1 Complete the preliminary intake forms**
Provide the demographic, contact, insurance, pharmacy, consent, and payment information requested in this packet.
- 2 Schedule your appointment**
After submitting the forms, call Barbara, Office Manager, at (631) 467-0867. She will assist with scheduling and answer questions about the process.
- 3 Complete the clinical questionnaires**
Complete the Life History Questionnaire before your first appointment. It helps Dr. Marie Surpris review your symptoms, personal and family history, educational background, and prior treatment in advance. Additional questionnaires may be provided based on your needs.

Questions? Please contact the office. We are happy to help you complete the process and prepare for your appointment.

Warm regards,

Marie Surpris, D.O.

Child, Adolescent & Adult Psychiatrist

Bien Être Psychiatry | www.drmariegsurpris.com | Office: (631) 467-0867

PATIENT INFORMATION

Please complete all applicable fields

Please complete and submit this packet before scheduling. After submission, contact Barbara, Office Manager, at (631) 467-0867 or 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 DETAILS

Patient Name:

Date of Birth:

Age:

Parent/Guardian (if applicable):

Address:

City:

State:

ZIP:

Home Phone:

Cell Phone:

Work Phone:

EMERGENCY CONTACT

Name:

Relationship:

Phone:

Preferred method for routine office communication:

☐

Phone

☐

Email

☐

Text message

Bien Être Psychiatry is a self-pay practice. Insurance information may still be needed for prescriptions, pharmacy benefits, or prior-authorization requests.

INSURANCE INFORMATION

Insurance Company:

Member ID #:

BIN #:

PCN #:

Group #:

PHARMACY INFORMATION

Pharmacy Name:

Pharmacy Phone:

Pharmacy Address:

ZIP:

OPTIONAL PHARMACY NOTES

List any pharmacy instructions, preferred location details, or information that may help the office process prescriptions.

TELEHEALTH CONSENT

- ☐ I understand that telehealth appointments are conducted through secure, HIPAA-compliant technology.
- ☐ I understand that technical interruptions may occasionally occur.
- ☐ I consent to participate in telehealth treatment.

OFFICE POLICIES

Appointments:

Initial evaluations are one-hour 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 or last-minute cancellations reduce availability for other patients, interrupt continuity of care, and may be charged in full.

By signing below, I confirm that I have read and understand the telehealth consent and office policies above.

Patient/Guardian Signature:

Printed Name:

Date:

Thank you for choosing Bien Être Psychiatry. To support a smooth experience, the office securely maintains a credit or debit card on file for each patient. Cards are charged only in accordance with office policies and include the standard 4% credit card fee.

PATIENT & CARDHOLDER INFORMATION

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 that this card may be used for telehealth appointments, missed-appointment or late-cancellation fees, and outstanding balances authorized by me.

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

This authorization remains in effect until I notify the office in writing that I wish to remove or replace this payment method. Removal may require another approved payment method before future appointments can be scheduled.

I certify that I am the authorized cardholder, that the information provided is accurate, and that Bien Être Psychiatry may process charges as outlined above. A receipt is available upon request.

Cardholder Signature:			
Printed Name:		Date:	