MEDICAL & PSYCHIATRIC HISTORY

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www.kjmpsychmd.com/office@kjmpsychmd.com

Please attach a copy of your government-issued ID Card.

Name:		**DOB:**
Address:		**SS#:**
City:	**State:**	**Zip:**

Home Phone:			
Mobile Phone:			
Email address:			
Preferred Contact (Circle One):	**Home**	**Mobile**	**Email**

Emergency Contact:
Phone(s):
Email:

Primary Care Physician:
Address:
Phone:

Current or Past Medical Conditions (Circle All that Apply):

Asthma/Respiratory Problems	Cardiovascular Problems	Intestinal Problems
High Blood Pressure	Epilepsy orSeizures	Thyroid Problems
Head Trauma	HIV/AIDS	Pain
Liver or Pancreas Problems	Diabetes	Weakness
STDs	Cancer	Dizziness
Other:		

Current or Past Mental Health Conditions (Circle All that Apply):

Depression Anxiety Bipolar Mood Disorder Psychosis Addiction

Outpatient Mental Health Treatment Including Current/Past Providers & Contact Info:

Inpatient/Residential Mental Health Treatment (Programs & Dates):

Have you ever attempted suicide? YES NO

Current List of Medicines/Doses:

Marital Status (Circle One): MARRIED SINGLE DOMESTIC PARTNER SEPARATED

Employment (Circle One): FULL TIME PART TIME UNEMPLOYED

Family History of Mental Illness or Addiction (Circle One): YES NO
Describe:

On Parole or Probation? (Circle One): YES NO

I have used the following substances:	Never	Now	Past	How Much	How Often	Date/Time of Last Use	Quantity Last Used
Alcohol							
Caffeine							
Marijuana							
Benzos / Other Sleep Aid							
Opioid Pain Medicines							
Legal Stimulants (pills)							
Cocaine & Crack							
Hallucinogens							
Inhalants							
Amphetamines & Meth							
PCP							
Methadone							
Heroin							
Ecstasy							
Other							

Outpatient Substance Abuse Treatment Including Programs & Contact Info:

Inpatient/Residential Substance Abuse including Programs and Contact Info:

Other Relevant Information:

I certify that the above information is accurate and complete.

_____

Hand written signature required. Today's Date

_____

Print Name Date of Birth

Consent to Participate in Telemedicine Consultation

Kenneth J Miller, MD, | http://www.kjmpsychmd.com
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1. I understand that telemedicine is different from traditional medicine in that sessions will occur remotely via live video-teleconference (VTC); I am familiar with the technology required for conducting telemedicine sessions via Skype (TM) or Facetime (TM).

2. I understand that some benefits of telemedicine include increased access to medical care and my personal convenience. I understand that some of the risks include (a) failure of VTC equipment such that appropriate medical decision-making becomes impossible and (b) breach of confidentiality due to encryption failure or legal/illegal investigation.

3. I understand that there may be technical limitations associated with receiving treatment via telemedicine; equipment may fail and my doctor may determine at any time that the quality of the connection is not sufficient to continue. I will provide (and will be provided) a telephone number to use in case of VTC failure.

4. I understand that VoIP-based VTC platforms such as Skype ™ use sophisticated data encryption to protect the confidentiality of VTC communication but I also understand that the security of communication via the internet, including email and VTC, may be compromised by malicious or directed investigation and may not be compliant with HIPAA. I hereby authorize communication with my doctor via telephone, fax, email, and VTC.

5. I understand that the laws that apply to the practice of medicine and to the privacy of health care information also apply to telemedicine.

6. I will notify my doctor if I am accessing him by VTC from a state other than where I am a legal resident. I will notify my provider if any other person can hear or see any part of any telemedicine session. It is my responsibility to ensure that my VTC equipment and software are operating properly prior to my appointment.

7. I understand that as a prerequisite for receiving treatment by VTC, I may be required to provide live electronic data regarding blood pressure and heart rate using an electronic auto-cuff. I may be required to visit with my family physician or PCP (and to provide corresponding records) as directed, and/or to obtain laboratory testing as recommended by my provider.

8. I understand that even if I am accessing the provider from my own home, my provider may contact police or 911 in the event of life threatening emergency.

9. I will not record any VTC session without my Dr Miller's written permission and I understand that Dr Millerr will not record any session without my written permission.

10. My questions have been answered to my satisfaction. I understand my alternatives to treatment via telemedicine, which may include traditional outpatient appointments. I understand the risks and benefits of receiving treatment via telemedicine and I hereby consent to participate in telemedicine.

11. I may revoke this consent at any time. I hereby agree to understand and agree to the above terms & conditions.

_____

Hand written signature required. Today's Date

Notice of Privacy Practices

Kenneth J Miller, MD, | http://www.kjmpsychmd.com
office@kjmpsychmd.com | Office: 614-832-8392 | Fax: 888-383-3873

MY PRACTICE IS COMMITTED TO PROTECTING INFORMATION REGARDING YOUR MENTAL HEALTH TREATMENT. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED, DISCLOSED AND SAFEGUARDED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures of Information
Protected health information (PHI) is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination, test results, diagnoses, treatment and applying for future care or treatment. It also includes billing documents for those services. *Under most circumstances, I will not share your PHI with anyone without your express permission.* However, this office is permitted by federal privacy laws to use and disclosure your PHI for purposes of treatment, payment, and health care operations. **Although I am not required to seek specific authorization from you for such disclosures, I will do so under most circumstances.**

- I may disclose your health care information for **treatment**. For example, I may inform your primary care physician or psychotherapist of a medication I am prescribing for you.
- I may disclose your health information for **payment**. For example, I may submit a bill to your health insurer to receive payment for your care, usually your diagnosis and what care I provided. In this case, I will disclose only the minimum amount of PHI necessary for this purpose.
- I may disclose health information for **health care operations**. For example, I may use your PHI for quality assessment, training programs, credentialing, medical review, etc. I will share only the minimum amount of PHI necessary for necessary business associates to help my office.

II. Disclosures not requiring authorization
In addition to uses and disclosures related to treatment, payment, and health care operations, I may also use and disclose your personal information without authorization for the following additional purposes:

- **Abuse, neglect or domestic violence:** As required or permitted by law, I may disclose health information about you to a state or federal agency to report suspected abuse, neglect or domestic violence. If such a report is optional, I will use my professional judgment in deciding whether or not to make such a report. If feasible, we will inform you promptly that
  we have made such a disclosure.
- **Appointment reminders and Other Health Services** I may disclose your PHI to remind you about an appointment or to inform you about treatment alternatives or other health related benefits and services that may be of interest to you, such as case management or care coordination.
- **Business associates** I may disclose PHI with business associates who are performing services on our behalf. For example, I may contract with a company to service and maintain my computer systems or to do billing. My business associates are obligated to safeguard your health information. I will share with our business associates only the minimum amount of PHI necessary for them to assist me.
- **Communicable diseases** To the extent authorized by law, I may disclose information to a person who may have been exposed to a communicable disease or who is otherwise at risk of spreading a disease or condition.
- **Coroners, medical examiners and funeral directors** I may disclose health information about you to a coroner or medical examiner, for example, to assist in the identification of a decedent or determining cause of death. I may also disclose health information to funeral directors to enable them to carry out their duties.
- **Food and Drug Administration** I may disclose your PHI to the FDA or an entity regulated by the FDA, in order, for example, to report an adverse event or a defect related to a drug or medical device.
- **Health oversight** I may disclose your PHI for oversight activities authorized by law or to an authorized health oversight agency to facilitate, auditing, inspection, or investigation related to our provision of health care, or the health care system.
- **Judicial or administrative proceedings** I may disclose your PHI in the course of a judicial or administrative proceeding, in accordance with my legal obligation.
- **Law enforcement** I may disclose your PHI to a law enforcement official for certain law enforcement purposes. For example, I may report certain types of injuries as required by law, assist law enforcement to locate someone such as a fugitive or material witness or make a report concerning a crime or suspected criminal conduct.
- **Personal representative** If you are an adult or emancipated minor, I may disclose your PHI to a personal representative authorized to act on your behalf in making decisions about your health care.
- **Public health activities** As required or permitted by law, I may disclose your PHI to a public health authority, for example, to report a disease or death.
- **Public safety** Consistent with my legal and ethical obligations, I may disclose your PHI based on a good faith determination that such disclosure is necessary to prevent a serious and imminent threat to the public or to identify or apprehend an individual sought by law enforcement.
- **Required by law** I may disclose your PHI as required by federal, state or other applicable law.
- **Specialized government functions** I may disclose your PHI for certain specialized government functions as authorized by law. This includes military command, determination of veteran's benefits, national security and intelligence activities, protection of the President and other officials, and the health, safety and security of correctional institutions.

- **Workers compensation** I may disclose health information about you for purposes related to workers compensation as required and authorized by law.

- **Serious threat** I may disclose your PHI to avert a serious threat to health or safety consistent with applicable law to prevent or lessen a serious imminent threat to the health or safety of a person or the public.
- Other uses and disclosures will be made only with your written authorization and you may revoke that authorization in writing as below (see "your rights").

IV. Your rights
Under law, you have certain rights regarding the health information that I collect and maintain about you. This includes the right to:

- Request that I restrict certain uses and disclosures of your health information; I am not, however, required to agree to a requested restriction.
- Request that we communicate with you by alternative means, such as making records available for pick-up, or mailing them to you at an alternative address, such as a PO Box. I will accommodate reasonable requests for such confidential communications.
- Request to review, or to receive a copy of the health information about you that is maintained in our files and the files of our business associates. If I am unable to satisfy your request, I will tell you in writing the reason for the denial and your right, if any, to request a review of the decision.
- Request that I amend the health information about you that is maintained in my files and the files of my business associates. Your request must explain why you believe my records about you are incorrect, or otherwise require amendment. If I am unable to satisfy your request, I will tell you in writing the reason for the denial and tell you how
  you may contest the decision, including your right to submit a statement (of reasonable length) disagreeing the decision. This statement will be added to your records.
- Request a list of disclosures of your health information. The list, known as the "accounting" of disclosures, will not include certain disclosures, such as those made for treatment, payment or health care operations. I will provide you the accounting free of charge. However, if you request more than one accounting in any 12 month period, I may impose a reasonable, cost-based free for any subsequent request. Your request should indicate the period of time in which you are interested (for example, "from May 1, 2003 to June 1, 2003"). I will be unable to provide you and accounting for any
  disclosures made before April 14, 2003, or for a period of longer than six years.
- Request a paper copy of this notice.
- Revoke authorizations that you made previously to use or disclose information by delivering a written revocation to my office, except to the extent information or action has already been taken.

In order to exercise any of your rights described above, you must submit your request in writing to me. If you have any questions about your rights, please speak with me in person or by phone during normal office hours.

V. My responsibilities
I will maintain the privacy of your health information as required by law; provide you with a notice as to our duties and privacy practices as to the information I collect and maintain about you; abide by the terms of this Notice; notify you if I cannot accommodate a requested restriction or request; and accommodate your reasonable requests regarding methods to communicate health information with you. I reserve the right to amend, change, or eliminate provisions in my privacy practices and access practices and to enact new provisions regarding the protected health information I maintain. If my information practices change, I will amend this Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of my "Notice" or by visiting my office by appointment and picking up a copy.

VI. To Request Information or File a Complaint
If you believe your privacy rights have been violated, you may file a written complaint by mailing it or delivering it to me. You may complain to the Secretary of Health and Human Services (HHS) by writing to Office for Civil Rights, US Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, DC 20201; by calling 1-800-368-1019; or by sending an email to OCRprivacy@hhs.gov. I cannot and will not make you waive your right to file a complaint as a condition of receiving care or penalize you for filing a complaint.

VII. Revisions to this Notice
I reserve the right to amend the terms of this Notice. If this Notice is revised, the amended terms shall apply to all health information that I maintain, including information about you collected or obtained before the effective date of the revised Notice. If the revisions reflect a material change to the use and disclosure or your information, your rights regarding such information, our legal duties, or other privacy practices described in this Notice, I will promptly distribute the revised Notice, post it in the waiting area(s) or my office and make copies available to my patients.

VIII. Receipt of this Notice
I have received a copy of this Notice of Privacy Practices.

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Hand written signature required. Today's Date

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Print Name Date of Birth