

PATIENT INFORMATION: (Please Print Clearly) Date: _____

Name _____
Last First Middle Initial

Address _____

Sex: **M** **F**
Date of Birth ____ / ____ / ____
SS# ____ / ____ / ____

Home Phone _____ Cell Phone _____

Check one preferred method of automated reminder calls:
____ 1) voice message on Home #
____ 2) voice message on Cell #
____ 3) text message on Cell #

Email Address: _____

Employer _____ Occupation _____

Marital Status: **S M W D** Spouse's Name: _____

RESPONSIBLE PARTY (if someone other than patient) :

Name _____ Relationship to patient _____

Employer _____

Address _____

Phone _____

Referral Source _____ Are you intending on filing for Disability? **Y N**

Neither this office, nor our providers, participate in Disability Evaluations.

INSURANCE INFORMATION:

Primary INS _____ Member ID# _____

Policy Holder _____ Relationship to patient _____

Date of Birth ____ / ____ / ____ Employer _____

* Secondary INS _____ Member ID# _____

I have provided a copy of the front and back of my insurance card **X** _____

Primary Care Physician _____ May we communicate with your PCP? **Y** or **N**

Individuals that I approve to share information with:

| <u>Name</u> | <u>Relationship</u> | <u>Phone#</u> |
|-------------|---------------------|---------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |

List of current medications: _____

I AUTHORIZE & ACCEPT RESPONSIBILITY FOR PAYMENT ON THIS ACCOUNT

X _____

Consent for Treatment:

Medication Management / Psychotherapy / Counseling +/or Assessment

I understand and voluntarily agree to participate in the evaluation and/or counseling through the above-named providers, I understand that I will be provided with an explanation of assessment and/or counseling procedures and their purposes.

I also give consent for treatment of medications, if indicated. And I understand that a reasonable explanation regarding treatment and medications will be provided.

Patients on controlled substances such as stimulants (i.e. Adderall, Ritalin), benzodiazepines (Ativan, Xanax), hypnotics (Ambien) and other potentially addictive medications, need close monitoring along with frequent follow-up. **These prescriptions cannot be refilled without an appointment** in order to comply with State and Professional regulations for usage of these medications.

For the first six months of therapy on medications, patients will be seen every month. After six months, and once symptoms are stable, based on assessment of use, patient’s appointments may be extended to every 8-12 weeks. Practice standards require all patients to be seen in person, at minimum, every three months. The exception to this is **patients on Stimulants (Adderall, Vyvanse) will be seen every month.**

X _____
Signature of patient, or legal guardian

Date

MEDICATION REQUESTS

Prescriptions are written to take the patient from appointment to appointment. If refills are needed in-between appointments due to missed appointments – there could be a fee of \$20.

Any medication requests need to allow 24-48 hours to be processed.

Please be aware of policy change in 2015 regarding controlled substances. **These may not be refilled without an appointment.**

(initial here) **X** _____

Financial Arrangements

As a courtesy, we will file your insurance claim for you. However, the information you provide us is important in filing the claim correctly. We cannot be responsible for any misinformation provided. Actual coverage and payment provided by the insurance company cannot be determined accurately until your insurance company provides an *Explanation of Benefits* (EOB).

You are responsible for any fees not covered or paid by your insurance carrier. It is your responsibility to ensure all preauthorization is received prior to any visit. Co-payments, deductibles, or any out-of-pocket expenses are **due at the time of service**, unless previous arrangements have been made with the office.

I hereby authorize this office to file my insurance on my behalf and assign all benefits to which I am entitled to the provider. I authorize release of any information necessary to process my claim.

I have read the above information, and I understand that I am financially responsible for all charges not covered or paid by my insurance carrier.

(initial here) X _____

As stated above, we do offer to file your insurance when appropriate. However, there are certain requests and services that are not covered by insurance, and thus would then be patient responsibility. Examples of some of these services:

* **Social Security Evaluations** * **Court-ordered evaluations** * **Short-term and/or Long-term Disability evaluations** * **letters and/or forms** to employers, insurance, or disability carriers... * **etc.**

All of these services require the time of the provider for which they need compensation. The patient may also be asked to schedule an appointment, which would allow them to clearly communicate the needs of these services.

I hereby confirm that I understand that requesting some of these services listed above may result in charges that fall to patient responsibility – due at the time of service.

(initial here) X _____

Emergencies

When you call our office after regular office hours, a voicemail will receive your call. You may leave a message to be handled when the staff returns, or if **your call is an emergency**; the voicemail will provide you with a number to our answering service. The answering service, in turn, will contact the doctor and have him/her return your call. Please be sure that you will be at the number you have given. Should you be unable to wait for the provider to contact you, please go to the nearest emergency room or call 911.

Again, it is stressed that these after-hours calls are for extreme situations, and not to be substituted for an appointment. The provider may charge the patient in such cases where it is determined that these privileges are being abused.

(initial here) X _____

Cancellation Policy

Your appointment represents a valuable period of time that obligated the presence of you and us. Should you need to change an appointment, please notify us at least 24 hours in advance, and please call if there is an emergency or other problem that prevents you from being at your appointment on time.

If you fail to provide 24-hour notification to this office of your intent to cancel or reschedule your appointment or if you miss an appointment without notifying this office, you will be charged a fee – MINIMUM OF \$50 - that will not be covered by your insurance carrier.

Your credit card information is required for this purpose.

I have read and understand the above information. (initial here) **X** _____

Credit Card Information and Policy

We do not accept American Express.

Name on Credit Card: _____

Credit Card Number: _____

Exp. Date: _____ Zip Code: _____ Three Digit Security Number: _____

With your permission this credit card information may also be on-file to pay your copay, co-insurance or patient responsibility for early and late-hour appointments.

(initial here) **X** _____

ACKNOWLEDGEMENT OF HIPAA

This signature confirms that the patient &/or patient guardian is aware that a copy of the HIPAA laws may be found in our lobby, and the patient could be provided a copy of their own upon request.

Patient/Guardian: _____
Please print

Signature: **X** _____

NAME: _____

DATE: _____

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(Use "✓" to indicate your answer)

| | Not at all | Several days | More than half the days | Nearly every day |
|---|------------|--------------|-------------------------|------------------|
| 1. Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| 2. Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |
| 3. Trouble falling or staying asleep, or sleeping too much | 0 | 1 | 2 | 3 |
| 4. Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| 5. Poor appetite or overeating | 0 | 1 | 2 | 3 |
| 6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down | 0 | 1 | 2 | 3 |
| 7. Trouble concentrating on things, such as reading the newspaper or watching television | 0 | 1 | 2 | 3 |
| 8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual | 0 | 1 | 2 | 3 |
| 9. Thoughts that you would be better off dead or of hurting yourself in some way | 0 | 1 | 2 | 3 |

FOR OFFICE CODING 0 + + +
=Total Score:

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

| Not difficult at all | Somewhat difficult | Very difficult | Extremely difficult |
|----------------------|--------------------|----------------|---------------------|
| ■ | ■ | ■ | ■ |