

Psychiatry SOUTH

New Patient/Client Registration Form

_____ Date of Birth: ____/____/____ Gender: ____
Last Middle First

_____ Marital Status: _____ Address: _____
Social Security Number _____

(Street number, name, city & zip)

Home Number: (____) ____ - ____ Cell: (____) ____ - ____ Work Number: (____) ____ - ____

Email Address: _____ @ _____ Employer: _____ Occupation: _____

Primary Care Physician: _____ PCP Phone Number: (____) ____ - ____

Referring Physician: _____ Phone Number: (____) ____ - ____

Pharmacy Name: _____ Pharmacy Phone Number: (____) ____ - ____

Identifying Information:

Preferred Language: _____ Ethnic Group (Circle): Hispanic or Latino // Not Hispanic or Latino // Unk or Decline

Race (Circle One): Caucasian or White // African American or Black // Asian // American Indian or Alaskan Native
Native Hawaiian or Other Specific Island // Other Race

Person Responsible for Payment:

_____ Relationship to Patient: _____ DOB: ____/____/____
Last Middle First

Emergency Contact(s):

Name: _____ Phone: (____) ____ - ____

Name: _____ Phone: (____) ____ - ____

Insurance Information (Primary):

Are you using any type of EAP (Employee Assistance Program) options? Y or N If yes, what company: _____

Insurer Name: _____ Contract Number or Subscriber ID: _____

Group Number: _____ (If Applicable) Authorization Number: _____

Subscriber Name (If different from self): _____

Subscriber Date of Birth: ____/____/____ Subscriber Social Security Number: ____ - ____ - ____

Subscriber's Employer: _____

Secondary Insurance:

Insurer Name: _____ Contract Number or Subscriber ID: _____

Group Number: _____ (If Applicable) Authorization Number: _____

Subscriber Name (If different from self): _____

Subscriber Date of Birth: ____/____/____ Subscriber Social Security Number: ____ - ____ - ____

Subscriber's Employer: _____

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General Practice Policies

Appointment Policy

An appointment is considered a mutual commitment between you and your clinician, and is subject to personal accountability and responsibility in keeping and managing the appointment. A 24 (twenty-four) hour notice is required to reschedule or cancel your appointment and to avoid automatic billing for payment of your session. Appointments for which you arrive late will still end at the appointed time. We do not overbook or double book, so the session is your responsibility for managing. As a courtesy, you may receive a reminder phone call, email and/or text for your appointment; however, responsibility for keeping your appointment is ultimately yours. All patients must arrive on time for their scheduled appointment. Failure to do so will result in a fee and rescheduling (*if applicable*) of the appointment. **Initials** _____

Payment for Services

Psychiatry South will directly bill your insurance company following your service. Your co-payment and any deductibles and balances, which may apply, will be collected when you check-in. If we are not billing an insurance company for your service, the full payment is due at the time of service. Psychiatry South accepts cash, debit and all forms of credit cards. Balances and payment arrangements are the patient's responsibility and should be treated as a personal commitment and subject to personal accountability. **Initials** _____

Confidentiality

The clinic operates in a "multi-disciplinary" way, meaning that the clinicians function as a team. Therefore, it is important to understand that the information in the chart is accessible to other clinicians in the office in order to provide you with quality and consistent care. However, no information about you or your care will be released to anyone outside the office without your consent or a court order. The only exceptions include suicide or homicide issues or child/elder abuse or neglect. You will complete a Release of Information that you can list person(s) to whom we may have communications with about you, your care and/or financial matters concerning your account here at PSI. Children (under the age of 17) have the right to confidential exchanges with clinicians. However, if there are issues that pose grave or immediate danger, these issues may be discussed with parents or legal guardians. Due to the charting nature of PSI and the clinical focus of our work with families (not legal), custody issues will not be addressed. Additionally, no court ordered evaluations will be performed. **Initials** _____

Treatment Issues

Our office staff will take messages during regular business hours. Please allow 48-72 (business) hours for a response as clinicians have varied schedules and are not in the office each day. Please do not wait until a crisis to contact our office. We are able to address routine concerns much more effectively than crisis concerns. If your concern involves a safety issue, please notify the front desk so that your clinician can be paged. If you have an after-hours concern, you may leave a message on our voicemail. If your need is emergent due to safety issues after-hours please call 911 or go to the nearest Emergency Department. **Initials** _____

Laboratory Policy

It may be medically necessary for your physician to request lab or radiologic tests in order to provide the best treatment possible. It is your responsibility, as our patient, to obtain the requested examinations. Our office will assist you as much as possible, but testing may require you to visit another facility or lab. If you do not obtain these tests within a reasonable time, your physician reserves the right to refuse to refill or prescribe further medications until tests are completed. Urine drug screens are performed on patients when necessary. All new patients and patients who are prescribed controlled medication will have an initial urine drug screen and will be subject to monthly UDS after. Any charges that may result from the UDS will be the responsibility of the patient if not covered by the insurance company. **Initials** _____

Dismissal

If you are "dismissed" from the practice it means you can no longer schedule appointments, get medication refills or consider us to be your physician/therapist. You have to find a physician/therapist in another practice. Common Reasons for Dismissal: Failure to keep appointments, frequent no-shows; Noncompliance, which means you have failed to follow physician instructions about an important health issue; Abusive (verbal or physical) to staff; Failure to pay your bill. We will send a letter to your last known address, notifying you that you are being dismissed. If you have a medical emergency within 30 days of the date on this letter, we will assist you with care options. We will forward a copy of your medical record to your new physician when a release is received. **Initials** _____

Consent

I have read and understand these policies in their entirety and agree to abide by these terms. I am also aware that if I have questions about this document, I am encouraged to bring them to PSI's attention.

Please indicate your agreement to the terms of this policy by signing below:

Date: ____/____/____

Printed Patient Name: _____ Signature Of Patient: _____

Printed Name of Responsible Party (if not patient): _____ Signature of Responsible Party: _____

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Medical Information Release Form and Notice of HIPAA

Patient Name: _____

Date of Birth: ____/____/____

Release of Information:

____ (Initials) Information is **not** to be released to anyone.

OR

____ (Initials) I authorize the release of information including the diagnosis, records, examinations rendered to me and claims (financial) information.

Information May Be Released To:

____ Spouse

Name of Spouse: _____

____ Child(ren)

Name(s) of Child(ren): _____

____ (Other)

Name(s): _____

Messaging:

Messages may be left (*initial where appropriate*):

Cell ____ (*Initials*)

Home ____ (*Initials*)

Work ____ (*Initials*)

Pre-Recorded/Appointment Reminder calls, emails and/or text messages may be left on my contact numbers listed on demographic form.

____ (*Initials*)

Coordination of Care:

Please list the names and phone numbers of other physicians from whom you are receiving care.

Name: _____ Phone Number: (____) _____ - _____

Name: _____ Phone Number: (____) _____ - _____

Name: _____ Phone Number: (____) _____ - _____

Psychiatry South strives to provide accurate care and therefore requests permission to speak with any other physician(s) who may also be treating you. Please indicate, by signing below, that PSI has your permission to speak with the above referenced physicians to coordinate your care.

HIPAA:

I have received notice of Psychiatry South HIPAA Privacy Practices and understand the document completely.

____ (*Initials*)

By signing below, I have read the above information and agree to all of the contents, including 'Coordination of Care' with my physicians.

Date: ____/____/____

Printed Patient Name: _____ Signature of Patient: _____

Printed Name of Responsible Party (*if not patient*): _____ Signature of Responsible Party: _____

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No-Show/Missed Appointments and Late Cancellation Policy

It is your responsibility as our patient to attend all scheduled appointments. If, for some reason, you are unable to make your appointment, it is your responsibility to cancel the appointment with a member of our staff, 24 (twenty four) hours prior to the scheduled appointment time. If you miss or fail to cancel an appointment, you will be charged an initial fee of \$75.00. Subsequent failures will result in full fee schedule charges ranging from \$100-\$210.00.

Habitual offenders, more than three missed appointments (late cancellation or no-shows) will be subject to discharge from the clinic.

Insurance will not be billed for these charges and are the patients sole responsibility.

Please indicate your agreement to the terms of this policy by signing below:

Date: ____/____/____

Printed Patient Name: _____ Signature Of Patient: _____

Printed Name of Responsible Party (if not patient): _____ Signature of Responsible Party: _____

MEDICATION REFILL POLICY

During the course of treatment at Psychiatry South, you may be prescribed medications. It is your responsibility, as the patient, to notify your physician if you need a refill at your scheduled appointment. Failure to show or frequently canceling your appointments whereby your medications would be refilled, without rescheduling, is not being compliant with clinic policies and you could be subject to discharge from the clinic. *Please note that no refills will be called-in after-hours or on the weekends or on holidays.* You must attend all scheduled appointments with your physician and not request medication refills when you have failed to follow-up appropriately.

Controlled Substances (including stimulant medications such as Concerta, Adderall, etc.) will be issued by your clinician on a **month-to-month** basis. Because these medications are highly regulated, prescriptions must be picked up and appointments must be kept. Also, in the event that a prescription for a controlled substance, or the medication itself, is lost it will not be re-written. Patients are subject to random urine drug screening and pill/capsule or film counts while being prescribed a controlled medication.

Please indicate your agreement to the terms of this policy by signing below:

Date: ____/____/____

Printed Patient Name: _____ Signature of Patient: _____

Printed Name of Responsible Party (if not patient): _____ Signature of Responsible Party: _____

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Controlled Substance(s) Contract

Controlled substance medications (*i.e. benzodiazepines, opioids, amphetamines*) are very useful, but have a high potential for misuse and are, therefore, closely controlled by local, state, and federal government(s). As a patient of Psychiatry South, you agree and understand the following (*initial each section*):

____ 1) I am responsible for the controlled substance medications prescribed to me. If my prescription is misplaced, stolen or if "I run out early," I understand this medication will not be replaced regardless of the circumstances.

____ 2) Refills of controlled substance medications:

A: Will be made only during regular office hours Monday through Friday, in person, once a month, and during a scheduled office visit. Refills will not be made at night, weekends or on holidays.

B: Will not be made if "I lost my prescriptions," "ran out early," or "misplaced my medication." I am solely responsible for taking the medication as prescribed and for keeping track of the remaining.

____ 3) I agree to comply with urine drug testing and pill counts at every appointment, thereby, documenting the proper use of any medications. If alcohol abuse is suspected, blood alcohol levels may be ordered.

____ 4) I understand that if I violate any of the above conditions, my prescriptions for controlled medications may be terminated. If the violation involves obtaining these medications from another individual, or the concomitant use of non-prescription illicit (illegal) drugs, I may also be reported to other physicians, pharmacies, medical facilities, and the appropriate authorities.

____ 5) I further understand that if I violate this controlled substance contract due to non-compliance of medical directions, such as, failure in taking medications as prescribed, utilizing other illicit drugs, or abuse of controlled medications, I may be subject to dismissal from Psychiatry South.

____ 6) I agree to keep my scheduled appointments, adhere to the payment policy outlined by the office and conduct myself in a courteous manner while in the office.

____ 7) I agree to not sell, share, or give any of medication to another person. I understand that such mishandling of my medication is a serious violation of this agreement and would result in my treatment being terminated without any recourse for appeal.

____ 8) I agree not to obtain medication from any doctors, pharmacies or other sources without telling my treating physician.

____ 9) I agree to take my medication as my doctor has instructed and not to alter the way I take my medication without first consulting my doctor.

____ 10) I agree to abstain from problematic alcohol usage, opioids, marijuana, cocaine and other addictive substances.

____ 11) I agree to fill all of my controlled medications at an in-state (Alabama) pharmacy. I will list my pharmacy of choice below and understand that I must utilize this pharmacy. If at any time, I choose to change my pharmacy, I will notify Psychiatry South and complete this information again:

- **Pharmacy Name:** _____ **Pharmacy Phone No.:** (____) _____ - _____

____ 12) I understand that Psychiatry South utilizes the State of Alabama Prescription Drug Monitoring Database and will monitor my prescription history via this source.

I have been fully informed of the above treatment agreement points and have a full understanding of my duties as a patient of Psychiatry South in regards to the controlled substances my physician is prescribing.

Patient Signature: _____ **Date:** ____/____/____

Physician Signature: _____ **Date:** ____/____/____

Patient Medical/Health Questionnaire

Patient Name: _____ Date of Birth: ____/____/____

- Are you allergic to any medications? Yes // No ; if yes, please list allergy and reaction: _____
- Medications you currently take with strength and how often taken (example: Metformin 500mg once a day for diabetes)
 - _____ Reason Taken: _____
 - _____ Reason Taken: _____
 - _____ Reason Taken: _____
 - _____ Reason Taken: _____
 - _____ Reason Taken: _____
 - _____ Reason Taken: _____

Use the back of this page for additional space.

- Have you had any surgeries? If so, please list type of surgery, place and year: _____
- Family History:
 - Mother
 - Age: _____ Living // Deceased
 - Any major medical issues or psychiatric history: _____
 - Father
 - Age: _____ Living // Deceased
 - Any major medical issues or psychiatric history: _____
 - Sister(s) and/or Brother(s)
 - Sister(s): Age(s): _____ Living // Deceased
 - Brother(s): Age(s): _____ Living // Deceased
 - Any major medical issues or psychiatric history: _____
 - Maternal Grandparents
 - Grandmother: Age: _____ Living // Deceased
 - Grandfather: Age: _____ Living // Deceased
 - Any major medical issues or psychiatric history: _____
 - Paternal Grandparents
 - Grandmother: Age: _____ Living // Deceased
 - Grandfather: Age: _____ Living // Deceased
 - Any major medical issues or psychiatric history: _____

- Social History:
 - Highest level of education completed: _____
 - Marital Status: _____
 - Number of children: _____ Son(s): _____ Daughter(s): _____
 - Do you exercise? Yes // No If yes, type of exercise (ex: walking, running, etc) _____
 - Are you sexually active? Yes // No
 - Do you drink alcohol? Yes // No If yes, Number of drinks _____ per day // week.
 - Do you use tobacco products? Yes // No If yes, what type and how often: _____
 - Caffeine Intake: Number of drinks _____ per day.
 - Employed? Yes // No Retired? Yes // No
 - Occupation? _____
 - Nature of work: Sedentary // Physical // Prolonged Standing // Highly Stressful
 - Duration of current profession: _____

Patient Name: _____ Date of Birth: ____/____/____

Review of Systems

- Constitutional
 - Fever Yes _____ No _____
 - Malaise (fatigue) Yes _____ No _____
 - Recent weight changes Yes _____ No _____
 - Change in appetite Yes _____ No _____
 - If yes, has appetite ____ increased or ____ decreased.
- Eyes
 - Blurred vision Yes _____ No _____
 - Double vision Yes _____ No _____
 - Visual Changes Yes _____ No _____
- Ears/Nose/Throat/Mouth
 - Hearing Loss Yes _____ No _____
 - Tinnitus (ringing in ears) Yes _____ No _____
 - Nasal congestion Yes _____ No _____
 - Nasal discharge Yes _____ No _____
 - Sore throat Yes _____ No _____
- Respiratory
 - Cough Yes _____ No _____
 - Shortness of breath Yes _____ No _____
 - Chest tightness or pain Yes _____ No _____
 - Wheezing Yes _____ No _____
- Cardiovascular
 - Murmur Yes _____ No _____
 - Palpitations Yes _____ No _____
 - Edema Yes _____ No _____
- Gastrointestinal
 - Nausea/Vomiting Yes _____ No _____
 - Change in bowel habits Yes _____ No _____
 - Diarrhea Yes _____ No _____
 - Constipation Yes _____ No _____
 - Abdominal Pain Yes _____ No _____
 - Blood in stools Yes _____ No _____
- Genitourinary
 - Blood in urine Yes _____ No _____
 - Painful urination Yes _____ No _____
 - Urinary Urgency Yes _____ No _____
 - Burning Yes _____ No _____
 - Itching Yes _____ No _____
- Musculoskeletal
 - Joint Pain Yes _____ No _____
 - Joint stiffness or swelling Yes _____ No _____
 - Numbness or tingling sensation Yes _____ No _____
- Neurological
 - Weakness Yes _____ No _____
 - Seizures or Convulsions Yes _____ No _____
 - Migraine Headaches Yes _____ No _____
 - Numbness Yes _____ No _____
 - Loss of balance Yes _____ No _____
 - Paralysis Yes _____ No _____
 - Tremors Yes _____ No _____

Patient Name: _____ Date of Birth: ____/____/____

• Psychiatric

- Difficulty concentrating Yes _____ No _____
- Insomnia Yes _____ No _____
- Changes in socializing Yes _____ No _____
- Substance Abuse Yes _____ No _____
- Anxiety Disorder Yes _____ No _____
- Irritability or mood changes Yes _____ No _____
- Suicidal thoughts or attempts Yes _____ No _____
- Anxiety Yes _____ No _____
- Depression Yes _____ No _____
- Forgetfulness Yes _____ No _____
- Nervousness Yes _____ No _____
- Quality of sleep Normal _____ Abnormal _____
- Previous use of psychotropic medications: List any psychiatric medications you have previously used: _____

• Integumentary

- Change in skin color Yes _____ No _____
- Change in hair or nails Yes _____ No _____
- Itching Yes _____ No _____
- Rash Yes _____ No _____

• Endocrine

- Heat/Cold Intolerance Yes _____ No _____
- Excessive Urination Yes _____ No _____

• Hematologic/Lymphatic

- Anemia Yes _____ No _____
- Easy bleeding or bruising Yes _____ No _____
- Malaise or fatigue Yes _____ No _____

• FEMALE

- Date of last menstrual period: ____/____/____
- Menstrual pain or tensions Yes _____ No _____
- Are you menopausal? Yes _____ No _____
- Date of last mammogram: ____/____/____
- Are you pregnant or breastfeeding? Yes _____ No _____
- Date of last pap smear" ____/____/____