MICHIGAN PSYCHIATRIC & PRIMARY CARE
702 West Lake Lansing Road
East Lansing, MI 48823
517.332.5342 ph
517.332.3325 fax

NEW PATIENT PSYCHIATRIC REGISTRATION

All forms must be completed entirely before an appointment will be scheduled

Name:_____

Please print (last) (first) (middle)

Address_____

(Street) (City) (State) (Zip)

Gender: M____ F____ Date of Birth____/____/_____ SS# ___-___-_____

Home Phone: ( ) ___-_____ Cell Phone: ( ) ___-_____ Email: _____

Marital status: Single ___ Divorced ___ Widow ____ Married____

Race: Caucasian ☐ Asian ☐ Native American ☐ African American ☐

Ethnicity: Non-Hispanic or Latino ☐ Hispanic or Latino ☐

Preferred Langue: English ☐ Spanish ☐ French ☐ ASL ☐ Other ☐

Employer: _____ Address: _____ Employer Phone: ( ) _____-_____

Emergency Contact: _____ Phone:( )_____-_____ Relationship: _____

Minor information (if patient is under 18)

Mothers name:_____ Fathers name: _____

Address:_____

Mothers Phone number ( ) _____-_____ Fathers Phone number ( ) _____-_____

Primary Insurance

Insurance carrier: _____ Subscriber name: _____ Date of Birth ___/___/_____

Relationship to subscriber: Self____ Spouse_____ Child____ Other____

Subscribers employer: _____ Subscriber SS# _____-_____-_____

Subscriber ID#_____ Group Number _____

RX Insurance name_____ RX ID#_____

Secondary Insurance

Insurance carrier: _____ Subscriber name: _____ Date of Birth ____/_____/_____

Relationship to subscriber: Self____ Spouse_____ Child____ Other____

Subscribers employer: _____ Subscriber SS# ___-___-_____

Subscriber ID#_____ Group Number _____

DIRECTIVES

Do you have a Durable power of Attorney for health care? Yes____ No_____

If yes who? _____ Relationship _____

If no, are you interested in information? Yes_____ No_____

CONSENT TO TREAT

I consent to medical treatment by Michigan Psychiatric & Primary Care and/or staff as deemed necessary in their judgment. I am aware that the practice of medicine and surgery is not exact science and that no guarantees have been made to me regarding the results of examinations, test or treatment. I understand that if major diagnostic studies or treatment procedures, such as surgery are required, I will be asked to give specific consent for those procedures.

_____ Initials

CONSENT FOR MEDICATION LIST

I consent to have my medication list imported into my medical records from the pharmacy by my treating physician.

_____ Initials

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process my medical insurance claims. I permit a copy of this authorization to be used in place of the original. I hereby authorize Michigan Psychiatric & Primary Care to apply for the benefits on my behalf for covered services rendered. I request that the payment from my insurance company be made directly to the provider. I certify that the information I have reported regarding my insurance coverage is correct. I understand that I am financially responsible for services rendered if not paid in full by my insurance company. I may revoke this authorization anytime in the future in writing.

_____ Initials

RELEASE OF INFORMATION TO CONSULTING PHYSCIANS

If in the opinion of the physician my condition requires me to be referred to another physician; I hereby authorize the release of the medical records pertaining to specific diagnosis in my physicians' possession, including records they generated and those of prior treating physicians.

_____ Initials

COMMUNICATION OF PROTECTED HEALTH INFORMATION

I, _____, allow the individuals listed below to have access to and to receive any of my health information (i.e. lab/diagnostic test results, medication changes, billing information, appointment information, etc.).

1. Name_____ Relationship_____ Phone # ( )_____-_____
2. Name_____ Relationship_____ Phone # ( )_____-_____
3. Name_____ Relationship_____ Phone # ( )_____-_____
4. Name_____ Relationship_____ Phone # ( )_____-_____

By signing below, you acknowledge that all the information contained in this form is accurate and true to the best of my knowledge. Your signature below acknowledges all aspects of this form.

PATIENT SIGNATURE_____ DATE_____

GUARDIAN SIGNTURE (if patient is minor) _____ DATE_____

Current Psychiatrist: _____ ( ) Yes ( ) No

Psychiatrist Office Name: _____ Office Phone: _____

Current Therapist/Counselor: _____ ( ) Yes ( ) No

Therapist/Counselor Office Name: _____ Phone: _____

What is the problem(s) for which you are seeking help?

1. _____

2. _____

3. _____

What are your treatment goals?

_____

_____

Current Concerns Please check all the symptoms below that apply to you:

□ Loss of interests/not enjoying things □ Guilt □ Decreased energy □ Concentration difficulty □ Loss of appetite □ Sleep difficulties □ Depression □ Feeling helpless/hopeless □ Episodes of crying □ Moody □ Feeling empty inside □ Afraid of rejection □ Angry/easily irritable □ Thoughts of suicide or self-harm □ Relationship problems □ Gambling	□ Easily distracted □ Taking risks □ Feeling overly important □ Racing thoughts □ Talkative □ Little need for sleep □ Very active/on the go all the time □ Anxiety □ Excessive worry □ Panic attacks □ Avoid going places □ Avoid being with others □ Checking things repeatedly □ Perfectionist □ Fears □ Gambling	□ Concerns with drinking alcohol □ Concerns with drug use □ Past alcohol/drug use □ Recreational drug use □ Thoughts of hurting others □ Legal problems □ Work problems □ Difficulty remembering □ Confusion □ Getting lost more often □ Difficulty making decisions □ Feeling suspicious at times □ Having strange experiences □ Hearing voices □ Seeing things □ Relationship problems

Suicide Risk Assessment

Have you ever had feelings or thoughts that you did not want to live? ( ) Yes ( ) No.

If YES, please answer the following. If NO, please skip to the next section.

Do you currently feel that you do not want to live? ( ) Yes ( ) No

How often do you have these thoughts? _____

When was the last time you had thoughts of dying? _____

Has anything happened recently to make you feel this way? ( ) Yes ( ) No

On a scale of 1 to 10, (ten being strongest) how strong is your desire to kill yourself currently?

Would anything make it better? ( ) Yes ( )No

Have you ever thought about how you would kill yourself? ( ) Yes ( ) No

Is the method you would use readily available? ( ) Yes ( )No

Have you planned a time for this? ( ) Yes ( ) No

Is there anything that would stop you from killing yourself? ( ) Yes ( ) No

Do you feel hopeless and/or worthless? ( ) Yes ( ) No

Have you ever tried to kill or harm yourself before? ( ) Yes ( ) No

Do you have access to guns? ( ) Yes ( ) No If yes, please explain.

List ALL current prescription medications and how often you take them: (if none, write none).

Allergies: (List if medication or environmental, include what type reaction):

Pharmacy Name, phone number and address	Medication Name	Total Daily Dosage	Estimated Start Date

Past Psychiatric medications. Please check all past medications.

Antidepressants	Stimulant Medications	Antipsychotics
❑ Anafranil (Clomipramine) ❑ Celexa (Citalopram) ❑ Cymbalta (Duloxetine) ❑ Desyrel (Trazodone) ❑ Effexor, (Venlafaxine) ❑ Elavil (Amitriptyline) ❑ ENSAM Transdermal Patch (Selegiline) ❑ Lexapro (Escitalopram) ❑ Luvox, (Fluvoxamine) ❑ Nardil (Phenelzine) ❑ Norpramin (Desipramine) ❑ Pamelor (Nortriptyline) ❑ Parnate (Tranylcypromine) ❑ Paxil, (Paroxetine) ❑ Pristiq (Desvenlafaxine) ❑ Prozac; Sarafem (Fluoxetine) ❑ Remeron, (Mirtazapine)	❑ Adderall ❑ Concerta, Daytrana TD Patch, Metadate,Ritalin (Methylphenidate) ❑ Dexedrine (Dextroamphetamine) ❑ Focalin (Dexmethylphenidate) ❑ Provigil ❑ Strattera (Atomoxetine) ❑ Tenex (Guanfacine) ❑ Vyvanse (Lisdexamfetamine)	❑ Abilify, (Aripiprazole) ❑ Clozaril, Fazaclo (Clozapine) ❑ Geodon, (Ziprasidone) ❑ Haldol (Haloperidol) ❑ Invega (Paliperidone) ❑ Loxitane (Loxapine) ❑ Mellaril (Thioridazine) ❑ Moban (Molindone) ❑ Navane (Thiothixene) ❑ Prolixin (Fluphenazine) ❑ Risperdal (Risperidone) ❑ Serentil (Mesoridazine) ❑ Seroquel (Quetiapine) ❑ Zyprexa (Olanzapine)

Anti-Anxiety / Insomnia Medications		Medications for Side Effects	Mood Stabilizers
❑ Ambien, (Zolpidem) ❑ Ativan (Lorazepam) ❑ Benadryl (Diphenhydramine) ❑ BuSpar (Buspirone) ❑ Dalmane (Flurazepam) ❑ Halcion (Triazolam) ❑ Klonopin (Clonazepam) ❑ Librium (Chlordiazepoxide ❑ Lunesta (Eszopiclone)	❑ Noctec (Chloral hydrate) ❑ ProSom (Estazolam) ❑ Restoril (Temazepam) ❑ Rozerem (Ramelteon) ❑ Serax (Oxazepam) ❑ Sonata (zaleplon) ❑ Tranxene (clorazepate) ❑ Unisome (Doxylamine) ❑ Valium (Diazepam) ❑ Vistaril, Atarax (Hydroxyzine) ❑Xanax (Alparazolam)	❑ Artane (Trihexyphenidyl) ❑ Benadryl (Diphenhydramine) ❑ Cogentin (Benztropine) ❑ Inderal (Propranolol) ❑ Parlodel (Bromocriptine)	❑ Carbatrol, Equetro, Tegretol (Carbamazepine) ❑ Depakote (Divalprotic Acid) ❑ Eskalith, Lithobid (Lithium) ❑ Lamictal (Lamotrigine) ❑ Topamax (Topiramate) ❑ Trileptal (Ocarbazepine)

List dates, dosages and response/side effects of past medication

_____

_____

Past Psychiatric Treatment:

Outpatient psychiatric treatment ( ) Yes ( ) No

If yes, please describe when, by whom, and the nature of the treatment:

_____

Inpatient psychiatric Hospitalization ( ) Yes ( ) No

If yes, please describe for when, where and for what reason:

_____

_____

Trauma History:

Do you have a history of being abused verbally, emotionally, physically, sexually or by neglect?

( ) Yes ( ) No

If yes, please describe when, where, and by whom: _____

Medical Information & History:

CONDITIONS *Check ☑ conditions you currently have or have had in the past*

☐ AIDS	☐ Bronchitis	☐ GERD (reflux)	☐ HIV positive	☐ Rhinitis
☐ Alcoholism	☐ Bulimia	☐ Glaucoma	☐ Kidney disease	☐ Sexually transmitted infection
☐ Anemia	☐ CAD / heart disease	☐ Goiter	☐ Liver disease	
☐ Anorexia	☐ Cancer, type_____	☐ Gout	☐ Multiple sclerosis	☐ Stroke
☐ Anxiety	☐ Chemical dependency	☐ Headaches	☐ Pacemaker	☐ Suicide attempt
☐ Arthritis	☐ Depression	☐ Heart attack	☐ Pneumonia	☐ Thyroid problem
☐ Asthma	☐ Diabetes	☐ Hepatitis	☐ Prostate problem	☐ Tuberculosis
☐ Bleeding disorder	☐ Emphysema/COPD	☐ Herpes	☐ Psychiatric care	☐ Ulcer(s)
☐ Breast lump	☐ Epilepsy	☐ High blood pressure	☐ Rheumatic fever	☐ Vaginal infections

☐ Other _____

Have you ever had an EKG? ( ) Yes ( ) No
If yes, when? _____
Was the EKG ( ) normal ( ) abnormal ( ) unknown
Do you have any current or ongoing medical concerns? _____
Do you have problems with pain? ( ) Yes ( ) No
Severity of your pain? (low) 1 2 3 4 5 6 7 8 9 10 (high)
Location of your pain? _____
Have your medical concerns interfered with your ability to work, relate to others, or be involved in activities outside of your home? ( ) Yes ( ) No
If yes, please explain: _____
Have you ever had an EKG? ( ) Yes ( ) No

If yes, when? _____ Was the EKG ( ) normal ( ) abnormal ( ) unknown

Do you have any current or ongoing medical concerns?

_____

Do you have problems with pain? ( ) Yes ( ) No

Severity of your pain? (low) 1 2 3 4 5 6 7 8 9 10 (high)

Location of your pain? _____

Have your medical concerns interfered with your ability to work, relate to others, or be involved in

activities outside of your home? ( ) Yes ( ) No

If yes, please explain:

_____

For Women:

Date of last menstrual period

Are you currently pregnant or do you think you might be pregnant? ( ) Yes ( ) No

Are you planning to get pregnant soon? ( ) Yes ( ) No

Current birth control method: _____

How many times have you been pregnant? _____ How many live births? _____

Do you have any concerns about your physical health that you would like to discuss? ( ) Yes ( ) No

Date and place of last physical exam:

_____

Additional Comments: _____

_____

Surgical History:

Date: Operation: Where: _____

Date: Operation: Where: _____

Date: Operation: Where: _____

*Additional medications can be listed on the back of this form or attached if needed.

Family Medical History:

Disease	Relationship to you	Disease	Relationship to you
Liver Disease:		Heart Disease:	
Chronic Fatigue:		Epilepsy/Seizures:	
Thyroid Disease:		Chronic Pain:	
Kidney Disease:		High Cholesterol:	
Diabetes:		High Blood Pressure:	
Asthma/Respiratory Problems:		Head Trauma:	
Stomach or Intestinal Problems:		Liver Problems:	
Cancer (list type):		Stroke:	
Fibromyalgia:			

Other:

Family Psychiatric History:

Has anyone in your family been diagnosed with or treated for:	
Bipolar disorder ( ) Yes ( )No Who:	Depression ( ) Yes ( )No Who:
Schizophrenia ( ) Yes ( ) No Who:	Post-Traumatic Stress ( ) Yes ( ) No Who:
Anxiety ( ) Yes ( ) No Who:	Alcohol Abuse ( ) Yes ( ) No Who:
Other Substance Abuse ( ) Yes ( ) No Who:	Violence ( ) Yes ( ) No Who:
	Suicide ( ) Yes ( ) No Who:
	Anger ( ) Yes ( ) No Who:

Were any family members treated with a psychiatric medication? ( ) Yes ( ) No Who:

Educational History:

Highest Grade Completed? _____ Where? _____

Did you attend college? ( ) YES ( ) NO Where? _____ Major? _____

What is your highest educational level or degree attained? _____

Occupational History:

Are you currently: ( ) Working ( ) Student ( ) Unemployed ( ) Disabled ( ) Retired

How long in present position? _____

What is/was your occupation? _____ Where do you work? _____

Have you ever served in the military? ( ) Yes ( ) No - If so, what branch and when? _____

Honorable discharge ( ) Yes ( ) No ( ) Other type discharge: _____

Relationship History and Current Family:

Are you currently: ( ) Married ( )Partnered ( )Divorced ( )Single ( )Widowed - How long? _____

If not married, are you currently in a relationship/relationship? ( ) Yes ( ) No - If yes, how long? _____

Are you sexually active? ( ) Yes ( ) No

How would you identify your sexual orientation/gender identity?

( ) straight/heterosexual ( ) lesbian/gay/homosexual ( ) bisexual ( ) Gender Identity/Pronouns used:

( ) unsure/questioning ( ) asexual ( ) other ( ) prefer not to answer

What is your spouse or significant other's occupation? _____

Describe your relationship with your spouse or significant other: _____

Have you had any prior marriages? ( ) Yes ( ) No - If so, how many? _____

How long? _____

Do you have children? ( ) Yes ( ) No - If yes, list ages and genders

Describe your relationship with your children: _____

List everyone who currently lives with you: _____

Spiritual Life:

Do you belong to a particular religion or spiritual group? ( ) Yes ( ) No

If yes, what is the level of your involvement? _____

Do you find your involvement helpful during this illness, or does the involvement make things difficult or stressful for you?

( ) more helpful ( )stressful

Legal History:

Have you ever been arrested? ( ) Yes ( ) No

Do you any pending legal problems? ( ) Yes ( ) No

If yes, please explain: _____

Exercise Level:

Do you exercise regularly? ( ) Yes ( ) No

How many days per week do you get exercise? _____

How much time each day do you exercise? _____

What kind of exercise do you do? _____

Substance Use:

How many caffeinated beverages do you drink a day?

_____ Coffee _____ Sodas _____Tea _____ Energy Drinks

Have you ever been treated for alcohol or drug use or abuse? ( ) Yes ( ) No

If yes, for which substances? _____

If yes, where were you treated and when? _____

How many days per week do you drink any alcohol? _____

What is the least number of drinks you will drink in a day? _____

What is the greatest number of drinks you will drink in a day? _____

In the past three months, what is the largest amount of alcoholic drinks you have consumed in one day? _____

Have you ever felt you ought to cut down on your drinking or drug use? ( ) Yes ( ) No

Have people annoyed you by criticizing your drinking or drug use? ( ) Yes ( ) No

Have you ever felt bad or guilty about your drinking or drug use? ( ) Yes ( ) No

Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to cure of a hangover?

( ) Yes ( ) No

Do you think you may have a problem with alcohol or drug use? ( ) Yes ( ) No

Have you used any street drugs in the past 3 months? ( ) Yes ( ) No

If yes, which ones? _____

Have you ever abused prescription medication? ( ) Yes ( ) No

If yes, which ones and for how long? _____

Check if you have ever tried the following:

	YES	NO	If yes, for how long and when was last use?
Methamphetamine	( )	( )	_____
Cocaine	( )	( )	_____
Stimulants (pills)	( )	( )	_____
Heroine	( )	( )	_____
LSD / Hallucinogens	( )	( )	_____
Marijuana	( )	( )	_____
Pain Killers	( )	( )	_____
Methadone	( )	( )	_____
Tranquilizers/ Sleeping Pills	( )	( )	_____
Alcohol	( )	( )	_____
Ecstasy	( )	( )	_____
Other	( )	( )	_____

Tobacco History:

Have you ever smoked cigarettes? ( ) Yes ( ) No Do you currently smoke? ( ) Yes ( ) No

How many packs per day on average? _____ For how many years? _____

Have you in the past? ( ) Yes ( ) No How many years did you smoke? _____

When did you quit? _____ Do you currently use pipes, cigars, or chewing tobacco? ( ) Yes ( ) No

Have you used either in the past? ( ) Yes ( ) No What kind? _____

How often per day on average? _____ For how many years? _____

Family Background and Childhood History:

Were you adopted? ( ) Yes ( ) No Where did you grow up? _____

List your siblings and their ages: _____

What was your father's occupation? _____ What was your mother's occupation? _____

Did your parents' divorce? ( ) Yes ( ) No - If so, how old were you when they divorced? _____

If your parents divorced, who did you live with? _____

Describe your father and your relationship with him: _____

Describe your mother and your relationship with her: _____

How old were you when you left home? _____

Has anyone in your immediate family died? ( ) Yes ( ) No Who and when?

_____

Date Completed: _____

Guardian Signature (if under age 18): _____ Date: _____

Emergency Contact: _____ Telephone#: _____

For Office Use Only:

Insurance Approved: yes___ no___ Initial/Date_____

Insurance Notes:

_____

_____

_____

_____

MAPS Approved: yes___ no___ Initial/Date_____

1st Appointment Date/Time:

_____

Consent for Psychiatric Service Treatment

I have chosen to receive mental health services in the form of Psychiatric/Therapy sessions for myself from Michigan Psychiatric Primary Care Clinic. My decision is voluntary, and I understand that I may terminate these services at any time, unless my participation has been mandated by a court of law.

Nature of Mental Health Services

I understand that during my treatment I may need to discuss material of any upsetting or uncomfortable nature in order to resolve my problems. I also understand it cannot be guaranteed that I will feel better after completion of treatment.

Compliance with treatment plan

I agree to participate in the development of an individualized treatment plan. I understand that consistent attendance is essential to the success of my treatment. Frequent "no shows" and/or late cancellations (less than 48hr notice), which there is a $100 fee for every time, may be grounds for termination of services, as well as failure to follow my treatment plan in any form.

Client Rights

- The right to be treated with dignity and respect by all staff
- The right to be involved in the planning and/or revision of my treatment plan
- The right to know about my treatment progress or lack thereof
- The right to reject the use of any therapeutic technique, and to ask questions at any time about the methods used
- The right to be spoken to in a language that is fully understood
- The right to a clean and safe environment
- The right to refuse to be video taped, audio recorded, or photographed
- The right to end treatment at any time unless court ordered
- The right to file a complaint or grievance about the agency or staff
- The right to confidentiality of clinical records and personal information according to federal and state law

Emergencies

I understand I may reach Michigan Psychiatric and Primary Care Clinic at 517-332-5342. If not available, I can leave a message and my call will be returned as soon as possible. If I have a life-threatening emergency, I am to call 911 or go to my nearest Emergency Room.

I have read, discussed and understood all the above information.

_____

Signature / Date

_____

Witness / Date

Notice of Privacy Practices – Patient Acknowledgement

Patient Name: _____ Date of Birth: _____

BY SIGNING THIS, I AGREE I HAVE RECEIVED THIS PRACTICE'S NOTICE OF PRIVACY PRACTICES written in plain language. The Notice provides in detail the uses and disclosures of protected health information that may be made by this practice, individual rights and practices' legal duties with respect to protect health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclosure protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- Individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
    - The right to complain to this practice and to the Secretary of HHS if I believe privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
    - The right to request restrictions on certain uses and disclosures of protected health information, and that this practice is not required to agree to a requested restriction.
    - The right to receive confidential communications of protected health information.
    - The right to inspect the copy of protected health information with reasonable charges.
    - The right to amend protected health information by adding notes.
    - The right to receive an accounting of disclosures of protected health information.
    - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Signature: _____ Date: _____

Relationship to patient (if signed by personal representative of patient): _____

Statement of Patient's Responsibilities

To the extent possible, Michigan Psychiatric and Primary Care Clinic requests that you,_____, as our patient will:

1. Provide accurate and complete information about your past illnesses, hospitalizations, medications and other matters relating to your health, and answer any questions concerning these matters.
2. Participate in your health care planning by talking openly and honestly about your concerns with your provider and other health care professionals.
3. Understand your health problems, treatment course and care decisions to your own satisfaction and ask questions if you do not understand.
4. Cooperate with your provider and other health care professionals in carrying out your health care plan both as a patient.
5. Participate and cooperate with our health care professionals in creating a treatment plan that meets your psychiatric, medical and social needs.
6. Inform the clinic or any of its professionals of the existence of any advanced directive (proxy, DNR, living will) you have created.
7. Take responsibility for the consequences and outcomes if you do not follow the care, service or treatment plan.
8. Provide accurate information related to insurance or other sources of payment. You are responsible for ensuring payment of your bills and you may be responsible for charges not covered by your insurance.
9. Treat other patients, visitors and staff with respect and consideration. Support mutual consideration and respect by maintaining civil language and conduct in interactions with staff and providers.
10. Follow instructions, policies, rules, and regulations in place to support quality care for patients and a safe environment for all individuals in the clinic.

Be considerate of your fellow patients, respecting their need for privacy and a quiet and safe environment.

Patient Signature:_____ Date:_____

Witness Signature:_____ Date:_____

MICHIGAN
PSYCHIATRIC &
PRIMARY CARE

Patient Name:_____

Patient DOB:_____

CONFIDENTIAL
CONSENT TO RELEASE MENTAL HEALTH, MEDICAL, OR SUBSTANCE ABUSE RECORDS

I authorize disclosure of records/information about me between:

Michigan Psychiatric & Primary Care Clinic, PC
6110 Abbot Road
East Lansing, MI 48823
ph: 517.332.5342 fax: 517.332.3325

and _____
Name

_____
Address

_____
City, State, Zip Code

_____
Phone Number *Fax Number*

The following information is being requested, please:

Disclose to the above party: ☐

Receive from the above party: ☐

Any of the following may be included:
(Please initial next to the information our office has permission to release)

____ Medical History
____ Test Results
____ Other medical (M.D./Nurses evals, notes, orders, medications
____ Social and/or Chemical Use history/assessment
____ Mental Health Assessments/consultations
____ Progress Reports/Notes
____ Change in Condition/aftercare planning
____ Discharge Summary
____ Limited Report (dates, discharge status, aftercare plan)
____ Billing/Payments
____ Other (Specify) _____

I understand that my chemical dependency records are protected under the federal regulations governing confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that my Mental Health clinic Records are afforded protection under state law. I understand that I can revoke this consent at any time. I understand this communication will reveal my presence as a patient at a treatment facility. *This consent expires one year from today's date, unless otherwise specified* _____*(date).*

Patient Signature _____ *Date:* _____

MICHIGAN
PSYCHIATRIC &
PRIMARY CARE

Financial Policy

BY SIGNING THIS POLICY, YOU AGREE YOU UNDERSTAND AND AGREE TO BE BOUND BY THE FOLLOWING TERMS:

1. **Payment is due at the time of service unless arrangements have been made in advance by your insurance carrier.** We accept most debit, Discover, MasterCard and Visa credit cards.
2. **You agree to disclose to Michigan Psychiatric & Primary Care Clinic all insurance coverage in effect at the time of service.** We will also need to know policy numbers, group numbers, the policyholder information and the guarantor information. You understand you need to provide copies of all current insurance cards or other identifying insurance information, failure to do so may result in additional charges to you to cover costs incurred by us.
3. **That your insurance policy is a contract between you and your insurance company. We cannot interfere with that contract.** As a service to you, we will file your insurance claim and you assign the benefits to the doctor – in other words, you agree to have your insurance company pay the doctor directly.
4. **We have made prior arrangements with many insurance companies and health plans to accept an assignment of benefits.** If we have a contract with your insurance company, we will bill them for you, and you may be required to pay a copayment at the time of your visit or after the insurance company or health plan adjudicates your claim.
5. **If a plan or insurance company with whom we do not have a prior arrangement insures you, we will prepare and send the claim for you on an unassigned basis.** This means the insurer may send the payment directly to you. If this is the case, our charges for your dare are due at the time of service.
6. **If we contract with an insurance company or plan, we must follow their master charge list and charge you the amounts they determine should be charged for services rendered.** We cannot guarantee your insurance will provide you with "in-network" benefits or any specific charges or payments. We will not "discount," "adjust" or "write off" amounts your insurance company determines are "allowed," "member liability" or should be paid by you.
7. **Not all insurance companies or plans cover all services.** In the event your insurance plan determines a service to be "not covered," you may be responsible for the entire charge. If you have an insurance plan with which we do not have a contract, you may be balance billed for any charges not covered by your plan. Payment is due upon receipt of an invoice from our office.
8. **If your insurance company or health plan does not pay the practice within a reasonable period, or in full, we will expect you to pay any outstanding charges.** If we later receive a check from our insurer, we will refund any overpayment to you.
9. **If you or your child has Medicaid, you can waive their right to have Medicaid pay for services. THIS WAIVER IS NOT REVOCABLE, ONCE CHOSEN, NO SERVICES WILL BE BILLED TO MEDICAID; YOU WILL BE RESPONSIBLE FOR THE PAYMENT OF ALL SERVICES.** If you chose to do this initial here: _____
10. **If a check is returned or not honored by your bank, you will be required to pay a $35.00 fee.**
11. **If we have to invoice you for an outstanding amount beyond the first invoice, you will be required to pay a $1.00 fee per page for each additional page thereafter.**
12. **If the amount owed Michigan Psychiatric & Primary Care Clinic is not paid within 90 days of invoicing, the account will be sent to a collection agency.** You will then be required to pay an additional fee equal to 50% of the original amount owed, in order to cover our costs and inconvenience involved with obtaining payment.
13. **Failure to cancel a scheduled appointment at least 48 hours before your scheduled appointment will result in a $100.00 fine.** Patient or patient guardian will be required to pay the $100.00 fee before or at the time of your next scheduled visit.

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time without direct notice to me and agree to be bound by any amendments.

Printed Patient Name | Signature of patient (or responsible party if minor) | Date

Patient/Provider Agreement for Ongoing Use of Controlled Medications and/or Psychotropic Medications

NAME: _____DATE OF BIRTH: _____DATE: _____

The use of the following medicine(s) _____

is only one part of my treatment for_____

What should I know about these medications?

This controlled medication may help me.

Anxiety and Sleep Medications can cause:

- Dizziness
- Memory Problems

These medicines require a face to face appointment every 3 months.

Combining these medicines with other drugs (like psychotropic sedating medications or other controlled substances like opiates or alcohol) can cause:

- Overdose
- Trouble breathing - due to Central Nervous System Depression
- Death

Stimulant medications (for ADD/ADHD) can cause:

- High Blood Pressure
- Fast or irregular heart rate
- Anxiety getting worse
- Hallucinations
- Aggression

These medicines require a face to face visit with the provider every 3 months.

I could become addicted to these medications.

If I must stop this medication for any reason, I may need to stop it slowly. Stopping it slowly will help me avoid feeling sick from withdrawal (flu like) symptoms. If I decide to stop my medication, I will contact my provider.

If I, or anyone in my family, has ever had a drug, substance or alcohol problems, I have a higher chance of getting addicted to this medication.

If I do not use this medication exactly as prescribed, I risk hurting myself and others. I will not increase my medicine dose without being told to do so by my provider.

I will inform my provider right away if another provider, like ER provider, specialist, dentist etc., prescribes a controlled substance.

This medicine will not be refilled early.

I oversee my medicine.

- I know my medicine will not be replaced if it is stolen without a police report filed. Lost medicine will not be replaced.
- I will not share or give this medicine to other people.

What can I do to help?

When asked, I will give a urine and/or blood sample to help monitor my treatment.

I will to go to appointments and tests set up by my provider. These may include, psychotherapy physical or occupational therapy, x-rays, labs, etc. If I miss my appointments it may not be safe for me to stay on the medicine and my provider may require an office visit before giving refills.

If my provider decides the risks outweigh the benefits of this medication, it will be stopped in a safe tapering manner.

How can I get my prescriptions?

I can only get this prescription from my provider with an appointment. Refills will be determined on an individual basis. Medications will only be given in 1-month supplies. I will need periodic office visits if continued usage is needed.

Only I, or someone I choose_____ (insert names) can pick up a prescription from the office. They may be asked to show identification.

What are reasons for ending this agreement?

I may not be able to obtain controlled prescriptions if I do not follow this agreement.

I know that by State of Michigan law, diverting these controlled substances for non-medical use (lying to get medications, giving, trading or selling these medications) is a crime that we will report.

Patient
Signature:_____Date:_____

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

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 figety 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	0	1	2	3
		add columns	+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. 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 _____

A2663B 10-04-2005