MICHIGAN
PSYCHIATRIC &
PRIMARY CARE

PRIMARY CARE INTAKE FORM

Registration Form

Name *

First Name Last Name

Date of Birth *

Month Day Year

Address *

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

Birth Gender *

- Male
- Female

Preferred Language *

English

Country of Origin *

United States

Social Security Number*

Marital Status *

- Single
- Married
- Divorced
- Widowed

Please Complete the following if the patient is a minor

Mother's Name

Phone Number

Area Code Phone Number

Please Complete the following if the patient is a minor

Father's Name

Phone Number

Area Code Phone Number

Responsible Party *

First Name Last Name

Date of Birth

Month Day Year

Address (if different from above)

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

Main Phone *

Area Code Phone Number

Can we leave a voicemail

Please Select

Work/Alt Phone

Area Code Phone Number

Can we leave a voicemail

Please Select

Email

example@example.com

Insurance #1 *

Policy # *

Group # *

Policy Holder *

Policy Holder Date of Birth *

Month Day Year

Insurance #2

Policy #

Group #

Policy Holder

Policy Holder Date of Birth

Month Day Year

How did you hear about us?

Emergency Contact Information (Other Than Responsibly Party)

Name *

First Name Last Name

Relationship *

Main Phone*

Area Code Phone Number

Work/Cell Phone

Area Code Phone Number

Health History

Registration Form

Reason For Visit *

Cardiologist

OB/GYN

Other Specialists

Is patient up-to-date on immunizations? *

- ◯ Yes
- ◯ No

Any recent foreign travel? *

- ◯ Yes
- ◯ No

Where?

Current Medications and Dietary Supplements: Type none if no medications

	Dose	Frequency	How long taking this?
Medication Name			
Medication Name			
Medication Name			
Medication Name			
Medication Name			
Medication Name			

Do you take a blood thinner? *

- ☐ No
- ☐ Coumadin
- ☐ Warfarin
- ☐ Aspirin
- ☐

Have you had an EKG? *

- ◯ No
- ◯ Yes

If yes when?

Was the EKG?

- ◯ Normal
- ◯ Abnormal
- ◯ Unknown

Do you have problems with pain? *

- ◯ No
- ◯ Yes

If Yes location of your pain

Severity of your pain

	1	2	3	4	5	6	7	8	9	10	
Worst	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	Best

Do you have a Durable Power of Attorney for health care?

- ◯ No
- ◯ Yes

If Yes who is that person and what is your relationship to them?

For Women: Date of last menstrual period

Month Day Year

Are you currently or do you think you might be pregnant?

- ◯ No
- ◯ Yes

How many times have you been pregnant?

How many live births?

When your mother was pregnant with you, were there any complications during pregnancy or birth?

- ◯ No
- ◯ Yes
- ◯ Unknown

Drug Allergies AND the reaction: Type none if no allergies

	When	Reaction	For how long?
Allergen Name			
Allergen Name			
Allergen Name			
Allergen Name			
Allergen Name			
Allergen Name			

Local Pharmacy with location *

Phone number *

Mail Order Pharmacy Name

Phone Number

Type a question: Type none if no surgeries

	Type of Surgery	Date
Colostomy		
Hysterectomy		
Gastric Bypass/Banding		
Joint Replacement		
Metal Implant		
IV port Appendectomy		
Stents (Biliary, cardiac, colon)		
Pacemaker		
Defibrillator		
Surgery		
Surgery		

Please list ALL serious accidents/injuries, hospitalizations, head injury or broken bones and dates

Please Check to indicate if you have ever had any of the following conditions

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia/Bulimia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding disorders
- ☐ Blood Transfusion
- ☐ Breast Lump
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical dependency
- ☐ Chronic Bronchitis
- ☐ Chickenpox
- ☐ Congestive heart failure
- ☐ Cirrhosis
- ☐ Crohn's
- ☐ Diabetes
- ☐ Eczema
- ☐ Emphysema
- ☐ Epilepsy/Seizure
- ☐ Gall stones
- ☐ GERD
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis A / B / C
- ☐ Heart Murmur
- ☐ Herpes
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Hypoglycemia
- ☐ Hernia
- ☐ IBS/IDB
- ☐ Irregular Pulse
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Learning Disabilities
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker/Defib.
- ☐ Pancreatitis
- ☐ Physical Limitations
- ☐ Pneumonia (recurrent)
- ☐ Polio
- ☐ Prostate problem
- ☐ Psychiatric care
- ☐ Psoriasis
- ☐ RSV
- ☐ Rheumatic Fever
- ☐ Scarlet Ever
- ☐ Stroke/TIA
- ☐ Suicide attempt
- ☐ Thyroid problems
- ☐ Tonsilitis
- ☐ Transfusions (blood)
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Ulcerative Colitis
- ☐ Vaginal Infections
- ☐ Venereal Disease
- ☐ Weight Loss
- ☐ Whopping Cough

Type of cancer?

Location of hernia?

Have you ever had any of the following?

	When	Where	Details(optional)
Colonoscopy			
Upper GI scope			
Mammogram			
Pap Smear			
Ultrasound			
CT			
MRI			

Family History and Social History

Registration form

Family History: Please complete the following information for your blood relatives

	Father	Mother	Brother(s)	Sister(s)	Children	Other
Deceased	☐	☐	☐	☐	☐	☐
Adopted Unknown family history	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐
Anemia	☐	☐	☐	☐	☐	☐
Bleeding disorders	☐	☐	☐	☐	☐	☐
Chrohn's disease	☐	☐	☐	☐	☐	☐
Colon polyps	☐	☐	☐	☐	☐	☐
COPD	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐
Drug/Alcohol Abuse	☐	☐	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐
Gout	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐

High Blood Pressure	☐	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐	☐
Migraines	☐	☐	☐	☐	☐	☐
Obesity	☐	☐	☐	☐	☐	☐
Psychosis	☐	☐	☐	☐	☐	☐
Smoking	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Thyroid disorder	☐	☐	☐	☐	☐	☐
Ulcers	☐	☐	☐	☐	☐	☐
Ulcerative Colitis	☐	☐	☐	☐	☐	☐
Colon Cancer	☐	☐	☐	☐	☐	☐
Esophageal Cancer	☐	☐	☐	☐	☐	☐
Leukemia	☐	☐	☐	☐	☐	☐
Pancreatic Cancer	☐	☐	☐	☐	☐	☐
Uterine/Breast Cancer	☐	☐	☐	☐	☐	☐
Other Cancers	☐	☐	☐	☐	☐	☐

Who resides in the home with the patient?

- ☐ **Father**
- ☐ **Mother**
- ☐ **Brothers**
- ☐ **Sisters**
- ☐ **Step-father**
- ☐ **Step-mother**
- ☐ **Grandfather**
- ☐ **Grandmother**
- ☐ **Aunt**
- ☐ **Uncle**
- ☐ **Domestic Partner**
- ☐ **Pets**

What type of pets and how many?

Highest grade completed *

Highest grade completed

	Attended?	Where	Major	Degree?
College				

Occupational History: Are you currently? *

- ◯ Working
- ◯ Student
- ◯ Unemployed
- ◯ Disabled
- ◯ Retired

What is/was your occupation?

For how Long?

If not married are you in a relationship?

- ☐ No
- ☐ Yes
- ☐

For how long?

Are you sexually active?

- ◯ No
- ◯ Yes
- ◯

How would you identify your sexual orientation/gender identity?

- ☐ Straight/Heterosexual
- ☐ Lesbian/Gay/Homosexual
- ☐ Bisexual
- ☐

Gender Identity/Pronouns used

- ○ Unsure/Questioning
- ○ Asexual
- ○ Prefer not to answer
- ○ _____

Spiritual Life: Do you belong to a particular religion or spiritual group?

- ○ No
- ○ Yes
- ○ Prefer not to answer
- ○ _____

If yes what is your involvement?

_____

Do you find this involvement helpful or does it make things more difficult or stressful?

_____

Do you exercise regularly? *

- ○ No
- ○ Yes

Exercise details

	Type of Exercise	How many days weekly	How much time in a day	
Type 1				
Type 2				
Type 3				

Substance Use: Do you consume or have you ever tried any of the following

	Yes/No	What Type?	How often/When	Amount/Quit?
Alcohol				
Caffeine				
Tobacco(cigarettes, pipe, chew, cigars)				
Methamphetamine				
Cocaine				
Stimulants (pills)				
Heroine				
LSD or Hallucinogens				

Marijuana				
Pain Killers				
Methadone				
Tranquilizers				
Sleeping pills				
Ecstasty				
Other				

Substance use questions continued

	No	Yes
Have you ever felt you ought to cut down on your drinking or drug use?	☐	☐
Have people annoyed you by criticizing your drinking or drug use?	☐	☐
Do you think you may have a problem with alcohol or drug use?	☐	☐
Have you used any street drugs in the past 3 months?	☐	☐
Have you ever abused prescription medication?	☐	☐
Have you ever been treated for alcohol or drug use or abuse?	☐	☐

Safety: Does your home have?

	NO	Yes
Rugs in the hallway	☐	☐
Handrails on the stairs	☐	☐
Poor Lighting	☐	☐

Safety: Do you experience?

	No	Yes
Domestic Violence?	☐	☐
Difficulty paying bills?	☐	☐

Please indicate if you are having any of the symptoms listed below. Do you now have or do you have a history of:
*

- ☐ Poor appetite
- ☐ Nausea or vomiting
- ☐ Hemorrhoids
- ☐ Abdominal Pain
- ☐ Vomiting blood
- ☐ Fever
- ☐ Infections/Injuries
- ☐ Dizziness
- ☐ Ringing ears
- ☐ Earache/discharge
- ☐ Sinus problems
- ☐ Rapid heart rate
- ☐ Swelling of ankles/feet
- ☐ High/Low Blood Pressure
- ☐ Chronic cough
- ☐ Rash
- ☐ Change in moles
- ☐ Bruise easily
- ☐ Frequent/urgent urination
- ☐ Numbness
- ☐ Heat intolerance
- ☐ Swollen glands
- ☐ Back/neck pain
- ☐ Anxiety
- ☐ Lump in testicle(men)
- ☐ Breast lump(women)
- ☐ Bleeding between periods(women)
- ☐ Difficulties in swallowing
- ☐ Bloating
- ☐ Constipation
- ☐ Changes in bowel habits
- ☐ Black tarry stools
- ☐ Fatigue
- ☐ Double/Blurred vision
- ☐ Hearing loss
- ☐ Sore throat
- ☐ Hay fever
- ☐ Vision loss/halos
- ☐ Chest pain
- ☐ Heart murmur
- ☐ Poor Circulation
- ☐ Spitting up blood
- ☐ Itching
- ☐ Scars
- ☐ Burning with urination
- ☐ Incontinence
- ☐ Disorientation
- ☐ Excessive thirst/urination
- ☐ Joint/muscle pain
- ☐ Depression
- ☐ Breast lump(men)
- ☐ Penis discharge(men)
- ☐ Extreme menstrual pain(women)
- ☐ Heartburn/indigestion
- ☐ Gas
- ☐ Diarrhea
- ☐ Rectal Bleeding
- ☐ Recent weight change
- ☐ Night Sweats
- ☐ Chills
- ☐ Mouth sores
- ☐ Bleeding gums
- ☐ Nose bleeds
- ☐ Hoarseness
- ☐ Shortness of breath
- ☐ Irregular pulse
- ☐ Varicose Veins
- ☐ Wheezing
- ☐ Hives
- ☐ Sores that won't heal
- ☐ Blood in urine
- ☐ Headaches
- ☐ Weakness
- ☐ Bleeding/bruising
- ☐ Arm/leg weakness/numbness
- ☐ Memory loss or confusion
- ☐ Erection difficulty(men)
- ☐ Sore on penis(men)

Confidential: Consent to Release Mental Health, Medical, or Substance Abuse Records

I authorize disclosure of records/information about me from (my previous provider listed below):

Name

Address

Street Address

City | State / Province

Postal / Zip Code

Phone Number

Area Code | Phone Number

Fax Number

Area Code | Phone Number

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

Check all types of information that MPPCC may:	**Disclose to the above party**
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)	☐
Other (Specify)*	☐

***Specify other types of information**

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.

Signature *_____ **Date** _____

General Consent for Treatment

You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedures to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing.

You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent form(s) prior to the test(s) or procedure(s).

Signature *_____

Date *

Month Day Year

Notice of Privacy Practices – Patient Acknowledgment

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 the 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 protect 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 and copy 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 *

Month Day Year

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

Statement of Patient Responsibilities

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

1. Provide accurate and complete information about your past illnesses, hospitalizations, medications, and other matter 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 professionals in carrying out your health care plan as a patient (including communicating by returning emails and calls from the staff and providers).
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. Requests or risk to commit insurance fraud will not be tolerated.
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. Abusive or threatening language or behavior directed at other patients, visitors or staff will not be tolerated.
10. Keep scheduled appointments and/or give appropriate notice of the need to cancel or reschedule your appointments.
11. Take medications as prescribed and follow dosage and transporting/care instructions.
12. It is not acceptable to try to alter or falsify official clinic documents, e.g. school notes, physical forms.
13. Follow instructions, policies, rules and regulations in place to support quality care for patients and a safe environment for all individuals at the clinic.

Michigan Psychiatric & Primary Care Clinic's goal is to make the office a warm and welcoming place where patients receive holistic care. We put a lot of thought and care into establishing policies for patient and financial obligations. Failure to comply with one or more of the obligations listed on the Statement of Patient Responsibilities Policy and/or the Financial Agreement (signed during intake paperwork completion) are the primary reasons for patients being discharged from the clinic. It is important to read and understand these.

Patients who are discharged are determined with great consideration and the clinic does not make these decisions lightly. Our office will notify you via mail that you have been discharged by the clinic and will provide a 30-day window to find another provider (from the date of this letter). Acute care and support will be provided in that 30-day window following discharge, inclusive of medication if needed.
policies.

Signature * _____

Date

Month Day Year

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 care 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 your 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 or reschedule a scheduled appointment at least 24 hours before your scheduled appointment will result in a $100 fine.** Patient or patient guardian will be required to pay the $100 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.

Signature * _____ **Date** _____