BILTMORE PSYCHIATRIC GROUP

6245 N 24th PARKWAY, SUITE 203, PHOENIX, AZ 85016
PHONE (602) 843-0035 FAX (602) 843-8963

NEW PATIENT INTAKE FORM

Name: _____

Age: _____ Date of Birth:_____ Place of Birth:_____

Single Married Separated Divorced Widowed

Nature of work:_____

GENERAL STATEMENT OF PROBLEM:

Who referred you to us? _____

Is this your first visit to a psychiatrist's office? yes_____ no _____

Why did you come to see us at this particular time?

_____

_____

Are you currently seeing a therapist or counselor? yes no

If yes, whom?: _____

May we contact them? yes no

Current Medications (including over the counter medications)

Name of Medication	Strength	How often	Physician	Reason for use

PAST PSYCHIATRIC HISTORY

Have you ever attempted suicide? Yes No

Have you ever intentionally injured yourself? Yes No

Have you ever been psychiatrically hospitalized? Yes No

Date	Hospital	Reason

Have you previously received psychiatric care elsewhere? Yes No

Year	Doctor	City	Reason for Leaving

Past Psychiatric Medications and their results:

Medication	Results

SUBSTANCE USE:

Do you drink alcohol? yes no How many drinks per week? _____

How much caffeine do you consume? _____

Do you smoke? yes no If yes, how much? _____

Do you use street drugs and/or marijuana? yes no

If yes, what and how often? _____

PAST MEDICAL HISTORY

Describe any **MAJOR** illnesses, accidents, or injuries:

Age/Year	Illness/Injury

Do you have allergies to medications? yes no

Check if you have **ever** had:

	Asthma		Seizures		Amnesia
	Migraines		Nightmares		Anorexia
	High Blood Pressure		Trouble Sleeping		Bulimia
	Diabetes Mellitus		Loss of Consciousness		Cancer

FAMILY HISTORY: Does anyone in your family have any of the following:

Condition	Who (e.g., grandmother)	Outcome
Depression		
Bipolar Disorder		
Schizophrenia		
Alcoholism		
Drug Abuse		
Psych Hospitalization		
Suicides		

PSYCHOSOCIAL BACKGROUND:

Tell how many children there are altogether in your family, and their ages:

Brothers ____ Ages _____

Sisters ____ Ages _____

PARENTS:

Father: Age: ____ Health: _____ Occupation:_____

Physical or emotional ailments: _____

Mother: Age: ____ Health: _____ Occupation: _____

Physical or emotional ailments: _____

How did you parents get along with each other? _____

Are you parents? married divorced/separated deceased

Were you raised by your parents? yes no If no, please explain _____

_____

DEVELOPMENTAL HISTORY:

Were there any medical complications in your delivery? yes no

Any particular problems or worries during childhood? _____

Were you the victim of any abuse as a child? yes no

What type?_____

Has it affected your life as an adult?_____

How?_____

SOCIAL HISTORY AND LATER CHILDHOOD:

How old were you when you started school? _____

Did you repeat or skip any grades? yes no If yes, which grades? _____

How old were you when you quit going? _____

How far did you get? _____

Why did you quit school when you did?_____

MILITARY SERVICE:

Did you serve in the military? yes no Which branch?_____

What was your discharge rank and type?_____

ADULT:

What are you present living arrangements? _____

Have you ever been married? yes no

Are you married now? yes no

If yes: Is this your first marriage? yes no

How many children do you have? _____ Ages: _____

What was the worst difficulty you were ever in with the law?

Do you own any weapons?_____

How many and what type?_____

What was the most traumatic event in your life?_____

What one word would you use to describe your personality? _____

What one word you use to communicate how you feel? _____

Is there anything that has not been addressed so far that you think the doctor should know? yes no If yes, please describe briefly: _____

_____

_____

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all 0	Several days 1	More than half the days 2	Nearly every day 3
1. Little interest or pleasure in doing things	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless	☐	☐	☐	☐
3. Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4. Feeling tired or having little energy	☐	☐	☐	☐
5. Poor appetite or overeating	☐	☐	☐	☐
6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down	☐	☐	☐	☐

	Not at all	Several days	More than half the days	Nearly every day
7. Trouble concentrating on things, such as reading the news-paper or watching television	☐	☐	☐	☐
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	☐	☐	☐	☐
9. Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐

If you checked off <u>any</u> problems, how <u>difficult</u> 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
☐	☐	☐	☐

Over the <u>last 2 weeks</u>, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	☐	☐	☐	☐
2. Not being able to stop or control worrying	☐	☐	☐	☐
3. Worrying too much about different things	☐	☐	☐	☐
4. Trouble relaxing	☐	☐	☐	☐
5. Being so restless that it is hard to sit still	☐	☐	☐	☐
6. Being easily annoyed or irritable	☐	☐	☐	☐
7. Feeling afraid as if something awful might happen	☐	☐	☐	☐

Signature _____ Date: _____

BILTMORE PSYCHIATRIC GROUP
NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. You have the right to obtain a paper copy of this notice upon request.

Patient Health Information

Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information.

How We Use Your Patient Health Information

We use health information about you for treatment, to obtain payment, and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances, we may be required to use or disclose the information without your permission.

Examples of Treatment, Payment, and Health Care Operations

Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your medical team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, and to pharmacists who are filling your prescriptions.

Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan.

Health Care Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, and to assess the care and outcomes of your case and others like it.

Special Uses

We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health related benefits and services that may be of interest to you.

Other uses and Disclosures

We may use or disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information without your permission for the following purposes:

Required by Law:
We may be required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries or events.

Research: We may use or disclose information for approved medical research.

Public Health Activities: As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.

Health Oversight: We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.

Judicial and Administrative proceedings: We may disclose information in response to an appropriate subpoena or court order.

Law enforcement purposes: Subject to certain restrictions, we may disclose information required by law enforcement officials.

Deaths: We may report information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.

Serious Threat to health or safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Military and Special Government Functions: If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.

Workers Compensation: We may release information about you for workers compensation or similar programs providing benefits for work related injuries or illness.

In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

Individual Rights

You have the following rights with regard to your health information. Please contact the office to obtain the appropriate form for exercising these rights.

Request Restrictions: You may request restrictions on certain uses and disclosures of your health information. We are not required to agree to such restrictions, but if we do agree, we must abide by those restrictions.

Confidential Communications: You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of your appointments.

Inspect and Obtain Copies: In most cases, at the discretion of your physician, you have the right to look at or get a copy of your health information. There may be a charge for the copies.

Amend Information: If you believe that information in your record is incorrect, or if important information is missing, you have the right to request that we correct the existing information or add the

missing information. Accounting of Disclosures: You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or health care operations.

Our Legal Duty

We are required by law to protect and maintain the privacy of your health information, to provide this notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the notice currently in effect.

Changes in Privacy Practices

We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area. You can also request a copy of our notice at any time.

Complaint

If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may discuss it with your attending physician. You may also send a written complaint to the U.S. Department of Health and Human Services. You will not be penalized in any way for filing a complaint.

Contact Person

If you have any questions, requests, or complaints, please contact our office at:
6245 N 24th Parkway, Suite 203
Phoenix, AZ 85016
602-843-0035

I, _____ hereby acknowledge receipt of the Notice of Privacy Practices given to me.

Signed:_____ Date: _____

If not signed, reason why acknowledgment was not obtained: _____

Staff Witness seeking acknowledgment: _____ Date:_____

Office Policies and Conditions of Treatment

I hereby authorize BPG to conduct an evaluation and perform treatment for myself and/or my dependents with regard to psychiatric or behavioral health problems.

My signature below indicates I have read and understood the following office policies and conditions of care:

Release of Information: The professional staff at BPG may disclose all or any part of the patient's medical and/or financial records to the following third parties:

1. any party liable for payment of all or part of the patient's financial obligation such as insurance companies, workman's compensation payers, government agencies, etc.
2. any concurrent treating professional, including psychiatrists, psychologists, social workers, and/or the therapist at the discretion of the responsible clinician.
3. Primary care, referring and other treating healthcare professionals to provide continuity of treatment or demonstrate medical necessity of continuing care.

Financial Agreement: If we are contracted with your plan, BPG will bill your insurance as a courtesy to you. Patient is responsible for supplying all insurance information, including any secondary insurance coverage, at the first appointment. Patient agrees to notify the office of any changes in insurance coverage within 10 days. **Patient is responsible for all charges not covered by insurance or if insurance cannot be verified, including any charges denied by insurance.**

Collection Fees: In the event that you fail to fulfill your financial obligations to the practice, BPG reserves the right to forward your account to an outside collection agency for resolution. Patient and/or guarantor will be responsible for any and all Collection Agency Fees, Attorney Fees, and any other Legal Fees associated with the debt incurred. ***Initial here to acknowledge understanding (_____)**

Co-payments and deductibles are due at the time of service; **a $15.00 billing fee** will be assessed if these payments are not made at that time. Checks returned for lack of funds (NSF) will be subject to **a $25.00 processing fee.** ***Initial here to acknowledge understanding (_____)**

Appointments: Professional services are by appointment only. There will be a fee charged (50% TO 100% of appointment charge) for all appointments missed that were not canceled with 24 hour advance notice. **NO EXCEPTIONS** ***Initial here to acknowledge understanding (_____)**

Office Hours: Our office hours are Monday through Thursday from 7:00 a.m. to 5:00 p.m. The nurse is available on Fridays for urgent calls from 8:00 a.m. until 12:00 p.m. From 12 p.m. to 5 p.m. on Fridays, after hours and on weekends, our on call physician is available for urgent matters through the answering service. Non urgent messages left on Friday will not be returned until the following Monday.

Phone Calls: Excessive calls from patients to Professionals between office visits are subject to a charge according to time.

Paperwork: There will be an additional charge for written reports, letters, correspondence, and disability forms not completed during a visit . **Minimum fee $35.00.**

Prescriptions: Contact your pharmacy directly for refills on prescriptions. The pharmacy will contact our office for approval. Please allow at least 48 hours for approval on all prescriptions as refills are processed Monday through Thursday 8:00 am to 5:00 pm and Friday 8:00 am to12 pm only.
Absolutely no routine refills will be approved during evenings or on weekends.

Signature (patient or guardian)_____ **Date:** _____

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PATIENT INFORMATION

Patient Name _____

Social Security # _____

Date of Birth _____

Address _____

_____

Home Phone (_____)_____

Work Phone (_____)_____

Cell Phone (_____)_____

Emergency Contact

Name_____

Phone # (_____)_____

Financial Agreement

If we are contracted with your insurance plan, BPG will bill your insurance company as a courtesy to you. Patient is responsible for supplying all insurance information, including any secondary insurance coverage, at the first appointment. Patient agrees to notify the office of any changes in insurance coverage within 10 days. **Patient is responsible for all charges not covered by insurance or if insurance cannot be verified, including any charges denied by insurance.**

Signature (patient or guardian)_____

Date _____