Patient Record Update

Version - 09-2024

Patient Information

Name:_____ SSN:_____

Add1:_____ DOB:_____

Add2:_____ ◯ Home Ph:_____

City:_____ ◯ Work Ph:_____

State:_____ Zip:_____ ◯ Cell Ph:_____

Email address: _____ (Please mark preferred phone number)

Guarantor Information - if different from self

Name:_____ SSN:_____

Add1:_____ DOB:_____

Add2:_____ Home Phone:_____

City:_____ Work Phone:_____

State:_____ Zip:_____ Relationship:_____

Employer Information

Name:_____ Occupation:_____

Add1:_____

City:_____

State:_____ Zip:_____

Insurance Information: Please provide copies of cards to the receptionist

Primary Insurance Information

Plan Name:_____ Policy#:_____

Cardholder:_____ DOB:_____

Relationship to patient: (circle one) __Self__Spouse__Parent__Other_____ SSN:_____

Have you contacted your insurance regarding your Mental Health benefits?_____

If yes, what are they?_____

Insurance Information: Please provide copies of cards to the receptionist

Secondary Insurance Information

Plan Name:_____ Policy#:_____

Cardholder:_____ DOB:_____

Relationship to patient: (circle one) __Self__Spouse__Parent__Other_____ SSN:_____

Have you contacted your insurance regarding your Mental Health benefits?_____

If yes, what are they?_____

Is your treatment covered by Workers' Compensation? Yes or No (circle) If yes, please list Insurer's Information: _____

Pharmacy Name:_____ Pharmacy Phone Number:_____

Address:_____

City:_____ State:_____ Zip:_____

Signature: Date:

FINANCIAL POLICY

Thank you for choosing our doctors and therapists to meet your needs. The following is a statement of our Financial Policy, which we ask you to read and sign prior to treatment.

YOUR PORTION OF PAYMENT IS DUE AT THE TIME OF SERVICE.

MEDICARE

I request that payment of authorized Medicare benefits be made or on my behalf to_____ _____ for any services furnished to me by that physician/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

COMMERCIAL INSURANCE

I hereby authorize the release of information necessary to file a claim with my insurance company and *assign benefits otherwise payable to me to the physician indicated on the claim.*

I understand that I am financially responsible for any balance not covered by my insurance carrier.

A copy of this signature is as valid as the original.

Signature_____ Date_____

MINOR PATIENTS (UNDER 18 YEARS OF AGE)

The parent/guardian/adult accompanying a minor child is responsible for full payment. If both parents have insurance, the parent with the first birthday in the year is most often the primary insurer. Please check your insurance policy to determine which company is primary before your appointment. In divorce cases, we will bill our participating insurances, but the parent who brings the child in for services is ultimately the responsible party.

FORENSIC EVALUATIONS

Forensic Evaluations are not covered by insurance and are paid in full prior to the evaluation unless alternative arrangements are made.

BILLING

A Billing statement covering your services will be mailed to you each month. We expect payment to be made on a timely basis. A past due account will be turned over to our collection agency if no payment has been made.

I have read, understand, and agree to this Financial Policy.

_____ _____

Signature of Patient of Responsible Party Date

CLIENT INFORMATION QUESTIONNAIRE
All Information Confidential

General Information Date_____

Name_____Age_____Gender_____DOB_____

Address_____State_____Zip_____County_____

Marital status: _____ Former last name (s)_____

Occupation_____Education_____

Employer name and address_____

Referring individual or agency_____Phone_____

List family members and all others in the home

Name	Age/Date of Birth	Relationship	Occupation

Do you have a Mental Health Care Advance Directive? ____Yes ____No

If yes, please provide us with a copy to keep on file.

Do you have a Mental Health Power of Attorney? ____Yes ____No

If yes: Name_____

Address_____

_____

Phone_____

To help us understand better what concerns you may have, please circle any of the following problems which pertain to you:

Anxiety	Depression	Fears
Shyness	Sexual Problems	Suicidal Thoughts
Separation	Divorce	Finances
Drug Use	Alcohol Use	Friends
Anger	Self-Control	Unhappiness
Sleep	Stress	Work
Relaxation	Headaches	Tiredness
Legal Matters	Memory	Ambition
Energy	Insomnia	Making Decisions
Loneliness	Inferiority Feelings	Concentration
Education	Career Choices	Health Problems
Temper	Nightmares	Marriage
Children	Appetite	Excessive Worry
Panic Attacks	Being a Parent	My Thoughts

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1. Are there any spiritual or cultural issues that you feel need to be taken into account in your treatment?_____Yes_____No If yes, please identify?_____
_____

2. What are your preferred pronouns? _____

DIET, SUBSTANCE USE AND LIFE STYLE ISSUES

1. Are you on a special diet? ☐No ☐Yes
   Describe_____

2. Current caffeine consumption (Soda, Coffee, Tea, Iced Tea, Etc)? ☐No ☐Yes
   Amount_____

3. Do you take Over The Counter (OTC) medications, herbal preparations, dietary supplements, etc? ☐No ☐Yes Type_____

4. Do you drink alcohol? ☐No ☐Yes
   Type_____Amount_____Last Drink_____

5. Have you ever had a problem with alcohol? ☐No ☐Yes
   Describe_____

6. Do you use any non-prescribed drugs, e.g. marijuana, cocaine, hallucinogens, opiods? ☐No ☐Yes
   Type_____Amount_____Last Used_____

7. Have you ever had a problem with substance abuse (other than alcohol)? ☐No ☐Yes
   Describe_____

8. Do you use tobacco in any form?
   ☐No ☐Yes Describe _____

9. Have you ever received mental health or substance abuse treatment? ☐None
   ☐Inpatient ☐Outpatient
   Place/Provider_____Year(s)_____Reason_____
   Place/Provider_____Year(s)_____Reason_____
   Place/Provider_____Year(s)_____Reason_____
   Place/Provider_____Year(s)_____Reason_____
   Place/Provider_____Year(s)_____Reason_____

10. When were you last seen by a mental health professional?
    _____ ☐N/A

11. Please list your family doctor and any other physicians or therapists involved in your care.
    _____
    _____
    _____

12. Do you have any health problems? ☐No ☐Yes
Please list:

_____ _____
_____ _____
_____ _____

13. Have you had any major, non-psychiatric hospitalization? ☐No ☐Yes

Place	Year	Reason

14. Have you any drug allergies or sensitivities? ☐No ☐Yes
Please list:

Drug	Symptom

15. Have you any other allergies or sensitivities (e.g. environmental, food, dye, latex, etc)
☐No ☐Yes Describe_____
_____

16. Please list all your current medications:

Drug	Dose	Frequency	Reason

17. In the past, have you ever been on medication for anxiety, depression, insomnia, etc?
☐No ☐Yes
If yes,

Drug	When	How Long	Effectiveness	Side Effects	Why Discontinued

18. Do you have any family history for mental illness or substance abuse? ☐No ☐Yes
Describe_____

19. Do you have any family history for medical problems, including diabetes, heart disease, cancer, Alzheimer's, asthma, etc? ☐No ☐Yes
Describe_____

PRIVACY NOTICE:

Your mental health care is private and confidential, and protected under federal (HIPAA) and state law.
You may access our Notice of Privacy Practices on our website, www.dgrbehavioralhealth.com, or request a copy in the office.

Signature_____

Dtae_____

DGR Policies

DGR BEHAVIORAL HEALTH ELECTRONIC COMMUNICATIONS POLICY

E-mail is only for scheduling or for a clinical reason that we can discuss ahead of time.

E-mail is not a substitute for discussions that should take place face-to-face.

E-mails should never be used for emergencies.

Do not e-mail your provider if you expect a quick response, as we only check e-mail occasionally.

We do not follow patients on social media.

Cell phones should be off (or in silent mode) during sessions. Secret recording of sessions is not permitted.

To protect your privacy and respect that of others, please do not have cell phone conversations in the waiting room.

Please review and keep for your records.

FRAGRANCE POLICY

This is a fragrance-free workplace. Thank you for not wearing any of the following during your visit: cologne, after shave lotion, perfume, perfumed hand lotion, fragranced hair products, and/or similar products. Our chemically sensitive co-workers and clients thank you.

CANCELLATION POLICY

We consider an appointment to be a commitment and an agreement. When an appointment is scheduled, the time is set-aside for you and no one else. Consequently, unlike other doctors' offices, we do not double or triple book patients. However, in order to do this, we must charge a fee for all appointments not cancelled within 24 hours of the appointment. If your appointment falls on a Monday, you may leave a message with the answering service over the preceding weekend.

Cancelled Appointments:	No charge will be made for any appointment cancelled with at least 24 hours advance notice.
Missed Appointments:	An appointment cancelled on less than a 24-hour notice, or an appointment missed without a notice of cancellation, will be billed a cancellation fee. This fee will not be charged to insurance, and is your responsibility to pay in full.
Exception:	Same-day cancellations because of serious medical/family emergencies or dangerous road conditions (snow and ice) will not be charged, as long as a telephone call is received in the office before the scheduled appointment time.

We will try to give you a reminder call if you have requested one. However, you are responsible for the appointment whether or not you receive that call.

I am aware of the cancellation policy and agree to the terms.

_____ _____

Signature Date

_____

Parent Signature if appropriate