PATIENT INFORMATION

DATE: ______ CHART #: ______ Social Security #: ______

Patient Name: ______
LAST FIRST MIDDLE MAIDEN

Address: ______ City: ______ State: ______ Zip: ______

Home Phone: ( ) ______ Work Phone: ( ) ______ ext. ______ DOB: ______

Relationship to Responsible Party: ☐ Self ☐ Spouse ☐ Child ☐ Legal Guardian

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Employer Name: ______ Employment Status: ☐ Full-time ☐ Part-time

Employer Address: ______ City: ______ State: ______ Zip: ______

Occupation: ______ Student: ☐ Full-time ☐ Part-time

Parents: (if patient is a minor) Father's Name: ______ Date of Birth: ______

Mother's Name: ______ Date of Birth: ______

Referring Physician: ______

RESPONSIBLE PARTY INFORMATION

COMPLETE IF OTHER THAN PATIENT

Responsible Party Name: ______

Address: ______ City: ______ State: ______ Zip: ______

Home Phone: ( ) ______ Work Phone: ( ) ______ ext. ______ DOB: ______

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Social Security #: ______ Employer Name: ______

Employer Address: ______ City: ______ State: ______ Zip: ______

Occupation: ______ Employment Status: ☐ Full-time ☐ Part-time

INSURANCE INFORMATION

INSURANCE ONE

Policyholder's Name (as it appears on card): ______ Policyholder's #: ______

Name of Plan: ______ Policy Group #: ______

Address to Mail Claims: ______ City: ______ State: ______ Zip: ______

Phone: ( ) ______ Effective Date: ______ Termination Date: ______

INSURANCE TWO

Policyholder's Name (as it appears on card): ______ Policyholder's #: ______

Name of Plan: ______ Policy Group #: ______

Address to Mail Claims: ______ City: ______ State: ______ Zip: ______

Phone: ( ) ______ Effective Date: ______ Termination Date: ______

INSURANCE THREE

Policyholder's Name (as it appears on card): ______ Policyholder's #: ______

Name of Plan: ______ Policy Group #: ______

Address to Mail Claims: ______ City: ______ State: ______ Zip: ______

Phone: ( ) ______ Effective Date: ______ Termination Date: ______

EMERGENCY CONTACT INFORMATION

Name: ______

Address: ______ City: ______ State: ______ Zip: ______

Home Phone: ( ) ______ Work Phone: ( ) ______ ext. ______

Relationship to Patient: ______

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PATIENT REGISTRATION FORM
DISCLOSURES & CONSENTS

Patient Name: ______________________________ ______________ Date of Birth: __________
First Name M.I. Last Name

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize direct payment of my insurance benefits to Advanced Psychiatric Services or the physician individually for services rendered to my dependents or me by the physician or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that Advanced Psychiatric Services is unable to collect from my insurance carrier for whatever reason.

MEDICARE/MEDICAID/PRIVATE INSURANCE BENEFITS:

I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependent's records that these programs may request. I hereby direct that payment of my or my dependent's authorized benefits be made direct to Advanced Psychiatric Services or the physician on my behalf.

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION:

I certify that I have received and read a copy of the Advanced Psychiatric Services Patient Information privacy Policy. I here authorized Advanced Psychiatric Services or the physician individually to release any of my or my dependent's medical or incidental non-public personal information that my be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

AUTHORIZATION TO MAIL, CALL OR E-MAIL:

I certify that I understand the privacy risks of the mail, phone calls and e-mail. I hereby authorize Advanced Psychiatric Services representative or my physician to mail, call or e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying Advanced Psychiatric Services to that effect in writing.

CONSENT TO TREATMENT:

I hereby consent to evaluation, testing and treatment as directed by my Advanced Psychiatric Service physician or his or her designee.

PATIENT SIGNATURE: ____ DATE: __________

GUARANTOR SIGNATURE: ______________________________________ DATE: __________
(If different from patient)

GUARANTOR NAME: (Please Print) ____

ADVANCED PSYCHIATRIC SERVICES

32905 W.12 Mile Rd ,Suite 410 Farming Hills, Michigan 48334

Acknowledgment/Declination of Notice of Privacy Practices

____

Patient Name(Please Print)

____________________ ____________________

Social Security Number Date of Birth

SELECT ONE AND SIGN BELOW

( ) I have read and understand the " NOTICE OF PRIVACY PRACTICES"

__________________________ __________________

Signature of Patient or Parent/Legal Guardian Date

( ) I have been offered the " NOTICE PRIVACY PRACTICES" and decline to read this notice.

__________________________ __________________

Signature of Patient or Parent/Legal Guardian Date

AUTHORIZATION TO RELEASE RECORDS

You are hereby authorized and requested to discuss or furnish my records to my Primary Care Physician:

____
Primary Physician's Name

____
Address, City, Zip Code

____

Or his representative, all my medical and drug records (including x-ray, if any) and reports, abstracts and summaries thereof, accident and/or police reports.

____
Date

____
Patient's Name

____
Address

____
City, State, Zip code

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

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 fidgety 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 in some way	0	1	2	3

FOR OFFICE CODING 0 + ______ + ______ + ______

=Total Score: ______

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
☐	☐	☐	☐

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

ADVANCED PSYCHIATRYIC SERVICES

MISSED APPOINTMENT/ LATE CANCELLATION POLICY (FOR PATIENTS)

I understand that I will be charged for missed appointments or cancellations when I provide less than 24- hour notice to my therapist or psychiatrist, (for Monday appointment ,call by Friday).

The charges are as follows:

Psychiatric Evaluation = $ 50

Therapist Appointment = $ 50

Medication review = $ 25

I understand that my insurance company does NOT pay for missed appointment or late Cancellation charges, and that payment is my responsibility.

When a missed appointment or late cancellation fee is charged, a notice will be mailed to my home.

I will be expected to submit payment upon receipt.

I also understand that keeping scheduled appointments is critical to achieving my treatment goals.

My signature indicates that I have reviewed, understand, and been offered a copy of this policy.

________________________________ ________________

Patient Signature Date

Informed Consent for Telemedicine Services

PATIENT NAME: ____________	DATE OF BIRTH:	MEDICAL RECORD #:
LOCATION OF PATIENT: ____________	____________	____________

PHYSICIAN NAME: ____________	LOCATION: ____________	DATE CONSENT DISCUSSED:
CONSULTANT NAME: ____________	LOCATION: ____________	
CONSULTANT NAME: ____________	LOCATION: ____________	____________

Introduction

Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and video
- Output data from medical devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Expected Benefits:

- Improved access to medical care by enabling a patient to remain in his/her ophthalmologist's office (or at a remote site) while the physician obtains test results and consults from healthcare practitioners at distant/other sites.
- More efficient medical evaluation and management.
- Obtaining expertise of a distant specialist.

Possible Risks:

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s);
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors;

Please initial after reading this page: ____________

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that I have the right to inspect all information obtained and recorded in the course of a telemedicine interaction, and may receive copies of this information for a reasonable fee.
4. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. My ophthalmologist has explained the alternatives to my satisfaction.
5. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.
6. I understand that it is my duty to inform my ophthalmologist of electronic interactions regarding my care that I may have with other healthcare providers.
7. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.

Patient Consent To The Use of Telemedicine

I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

I hereby authorize ______________________________ ***(name of ophthalmologist)*** to use telemedicine in the course of my diagnosis and treatment.

Signature of Patient (or person authorized to sign for patient): ______________________________ *Date:* ______________

If authorized signer, relationship to patient: ______________________________

Witness: ______________________________ *Date:* ______________

I have been offered a copy of this consent form (patient's initials) ______