

Office Use Only:
Provider: _____
DX: _____
Initial Eval Date: _____

RIVERVIEW PSYCHIATRIC MEDICINE, PC
PATIENT REGISTRATION FORM

DATE: _____
PATIENT NAME: _____
SOCIAL SECURITY #: _____
BILLING ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
HOME ADDRESS: (IF DIFFERENT FROM BILLING ADDRESS) _____
DATE OF BIRTH: _____ AGE: _____ HOME#: _____
WORK/CELL #: _____
WHO REFERRED YOU TO THE OFFICE: _____
FAMILY DOCTOR (PCP) _____ TELEPHONE #: _____
IN CASE OF EMERGENCY NOTIFY: _____ TELEPHONE #: _____
PRIMARY INSURANCE: _____ ID #: _____
PREAUTHORIZATION NUMBER: _____
SECONDARY INSURANCE: _____ ID #: _____
INSURED'S SOCIAL SECURITY #: _____
NAME: _____ DOB: _____

OFFICE POLICY

PLEASE READ AND SIGN THE FOLLOWING INFORMATION CONCERNING THE POLICIES OF THIS OFFICE. YOU WILL BE GIVEN A COPY FOR YOUR RECORDS.

AUTHORIZATION:

I, (your name) _____, hereby authorize Riverview Psychiatric Medicine, PC as needed and/or requested:

- ___ To release any applicable mental health information to my primary care physician (PCP) named above.
- ___ To release any applicable substance abuse information to my PCP named above.
- ___ Not to release any information to my PCP named above.

I may revoke this authorization at any time except to the extent that action has been taken in reliance upon it. If I do not revoke this authorization, it will expire in one (1) year after I have terminated treatment.

I have read and understand this statement: _____
Signature of patient or guardian

INSURANCE PAYMENT ORDER:

I, (your name) _____ hereby authorize my insurance company to pay directly to Riverview Psychiatric Medicine, PC all benefits due to me. This policy was in full force and effect at the time of treatment. I understand that I am financially responsible for all balances remaining after payment of possible insurance benefits, and that, should it become necessary, any and all reasonable collections and attorney fees will be added to my bill. I also understand that my health information will be used, as needed, to obtain payment for my health care services from my insurance providers. This may include certain activities the Riverview Psychiatric Medicine, PC staff may need to undertake before my health care insurer approves or pays for health care services recommended for me; such as determining eligibility or coverage for benefits, reviewing services provided to me for medical necessity, and undertaking utilization review activities.

I have read and understand this statement: _____
Signature of patient or guardian

PAYMENT POLICY:

You are responsible for all co-payments and/or fees at the time of service, otherwise billing fees will be incurred. If another party is responsible for your payments, please let us know prior to your visit so that we may make the necessary arrangements.
A fee of \$35.00 will be charged for any return checks, along with a processing fee.

I have read and understand this statement: _____
Signature of patient or guardian

CANCELLATION POLICY:

All cancellations and/or rescheduling of appointments MUST be done at least 24 hours in advance. Patients, who cancel the day of an appointment or do not show, will incur a \$75.00 cancellation/no show fee. If your appointment is on a Monday, and you leave a message on the machine over the weekend, **that does not constitute 24 hour notice**. That appointment would have had to be changed on the Friday prior. A fee will be assessed as well. Confirmation calls are done as a courtesy to patients; however, there are times we cannot make them. Please do not rely on our call.

I have read and understand this statement: _____
Signature of patient or guardian

INFORMED CONSENT FOR TREATMENT:

I, (your name) _____ agree and consent to participation in the behavioral health care services offered and provided at/by Riverview Psychiatric Medicine, PC, a behavioral health care facility. I understand that I am consenting and agreeing only to those services that the above provider is qualified to provide within (1) the scope of the provider’s license, certification, and training; or (2) the scope of the license, certification, and training of the behavioral health care providers directly supervising the services received by the patient. If the patient is under the age of eighteen (18) or unable to consent to treatment, I attest that I have legal custody of this individual and am legally authorized to initiate and consent to treatment on behalf of this individual.

I have read and understand this statement: _____
Signature of patient or guardian

RIVERVIEW PSYCHIATRIC MEDICINE, PC
MEDICAL AND PSYCHIATRIC HISTORY

This questionnaire is an important part of providing you with the best health care possible. Your answers will help in understanding problems that you may have. Please answer every question to the best of your ability.

1. Are you in good physical health? Yes No

2. Has there been any change in your general physical health in the last year?..... Yes No

3. Date of your last physical examination (on or about) _____

4. Have you ever had any serious illness or operation? Yes No

If so, please list:

5. Are you currently under the care of a physician for any physical condition? Yes No

6. Are you taking any prescription drugs or medications at present time? Yes No

If so, please list:

NAME OF MEDICATION	STRENGTH IN MG	DATE BEGAN	REASON FOR TAKING

Have you ever been hospitalized? Yes No

If yes, please list and explain:

REASON	DATE OF HOSPITALIZATION	LOCATION (CITY, STATE)	TREATMENT RECEIVED

Do you, or have you ever had, any of the following problems?

a. Rheumatic Heart Disease	Yes	No	t. Anemia	Yes	No
b. Jaundice	Yes	No	u. Arteriosclerosis	Yes	No
c. Rheumatic Fever	Yes	No	v. Blood Clotting Problems	Yes	No
d. Arthritis or Rheumatism	Yes	No	w. Asthma	Yes	No
e. Congenital Heart Disease	Yes	No	x. Venereal Disease/STD	Yes	No
f. Stomach Ulcer	Yes	No	y. Hay Fever	Yes	No
g. Cardiovascular Disease	Yes	No	z. Bladder problems	Yes	No
h. Kidney Disease	Yes	No	Aa. Hives	Yes	No
i. Heart Trouble	Yes	No	Bb. Cancer	Yes	No
j. Tuberculosis	Yes	No	Cc. Skin Rash	Yes	No
k. Heart Attack	Yes	No	Dd. Tick Bite	Yes	No
l. Under active Thyroid	Yes	No	Ee. Fainting Spells	Yes	No
m. Coronary Insufficiency	Yes	No	Ff. Lyme Disease	Yes	No
n. Overactive Thyroid	Yes	No	Gg. Seizures	Yes	No
o. Coronary Occlusion	Yes	No	Hh. Diabetes	Yes	No
p. Glaucoma	Yes	No	Ii. Liver Disease	Yes	No
q. High Blood Pressure	Yes	No	Jj. Hepatitis	Yes	No
r. Blood Disorder	Yes	No	Kk. Other (explain)	Yes	No
s. Low Blood Sugar	Yes	No			

Do you have any physical disease or condition not listed above that you think the doctor should know? Yes No

If so, please explain: _____

Have you ever taken any prescription drugs or medications for emotional or psychiatric conditions? Yes No

If so, please list and explain:

<i>NAME OF MEDICATION</i>	<i>STRENGTH IN MG</i>	<i>DATE BEGAN</i>	<i>DATE ENDED</i>	<i>REASON FOR TAKING</i>	<i>REASON DISCONTINUED</i>

Are you taking any non prescription drugs, including natural remedies and vitamins? Yes No

If so, please list and explain:

<i>NAME OF MEDICATION</i>	<i>STRENGTH IN MG</i>	<i>DATE BEGAN</i>	<i>REASON TAKING</i>

Are you aware of or has a physician ever told you of any allergies/adverse reactions to any medications or drugs? Yes No

If so, please list and explain:

<i>NAME OF MEDICATION</i>	<i>REACTION</i>

MENTAL HEALTH QUESTIONNAIRE

1. In chronological order, please list all psychiatrists and/or psychotherapists, (psychologists, nurse practitioners, certified social workers, counselors, etc) who have attended you beginning with the present:

<i>NAME</i>	<i>TITLE/PROFESSION</i>	<i>TREATMENT (THERAPY, MEDS, ETC.)</i>	<i>DATE STARTED</i>	<i>DATE ENDED</i>	<i>REASON DISCONTINUED</i>

2. During the last four (4) weeks, have you been bothered by any of the following problems?

- a. Stomach pain? Yes No
- b. Back pain? Yes No
- c. Pain in your arms, legs, or joints..... Yes No
- d. Menstrual cramps, or problems with your period? Yes No
- e. Pain or problems with your periods? Yes No
- f. Headaches? Yes No
- g. Chest pain? Yes No
- h. Dizziness? Yes No
- i. Fainting Spells?..... Yes No
- j. Feeling your heart pound or race?..... Yes No
- k. Shortness of breath? Yes No
- l. Constipation? Yes No
- m. Loose bowel or diarrhea? Yes No
- n. Nausea, gas, or indigestion? Yes No

3. Over the last two (2) weeks, have you been bothered by any of the following problems?

- a. Little to no interest or pleasure in doing things?..... Yes No
- b. Feeling down, depressed, or hopeless? Yes No
- c. Trouble falling asleep or staying asleep?..... Yes No
- d. Sleeping too much?..... Yes No
- e. Feeling tired or having little energy? Yes No
- f. Poor appetite or overeating?..... Yes No
- g. Feeling bad about yourself? Yes No
- h. Feeling that you are a failure, or have let others down?..... Yes No
- i. Trouble concentrating on things such as reading, watching TV? Yes No
- j. Moving or speaking slowly that other people have noticed?..... Yes No
- k. Being so fidgety or restless that other people have noticed? Yes No
- l. Thoughts that you would be better off dead or hurting yourself in any way? Yes No
- m. Persistently elevated, expansive mood?..... Yes No
- n. Inflated self esteem? Yes No
- o. Pressured to keep talking?..... Yes No
- p. Racing thoughts? Yes No
- q. Distractibility?..... Yes No
- r. Impulsiveness (buying sprees, sexual indiscretions, foolish business investments?) Yes No

4. Questions about anxiety:

- a. In the last four (4) weeks have you had an anxiety attack? (suddenly feeling fear or panic)..... Yes No
If you checked no, go to question 6
- b. Has this ever happened before? Yes No
- c. Do some of these attacks come suddenly out of the blue, or in situations where you don't expect to be nervous or uncomfortable?..... Yes No
- d. Do these attacks bother you a lot or are you worried about having another attack?..... Yes No

5. Think about your last bad anxiety attack:

- a. Were you short of breath? Yes No
- b. Did your heart race, pound, or skip?..... Yes No
- c. Did you have chest pain or pressure?..... Yes No
- d. Did you sweat? Yes No
- e. Did you feel as if you were choking? Yes No
- f. Did you have hot flashes or chills?..... Yes No
- g. Did you have nausea or an upset stomach, or the feeling that you were going to have diarrhea? Yes No
- h. Did you feel dizzy, unsteady, or faint?..... Yes No
- i. Did you tremble or shake?..... Yes No
- j. Were you afraid you were dying?..... Yes No

6. Over the last four (4) weeks, have you been bothered by the following problems?

- a. Feeling nervous, on edge, or worried a lot about different things?..... Yes No
If you checked no, go to question 7
- b. Feeling restless so that it is hard to sit still? Yes No
- c. Getting tired very easily?..... Yes No
- d. Muscle tension, aches, or soreness?..... Yes No
- e. Trouble falling asleep or staying asleep?..... Yes No
- f. Trouble concentrating on things, such as reading, watching TV? Yes No
- g. Obsessions (fear of contaminations, intrusive thoughts of harm, need for order or symmetry)? ... Yes No
- h. Becoming easily annoyed or irritated?..... Yes No
- i. Compulsions (checking doors, oven, washing hands)? Yes No
- j. Social anxiety (center of attention, avoiding social situations)? Yes No

7. Questions about eating

- a. Do you often feel that you can't control what or how much you eat? Yes No
- b. Do you often eat, within any 2 hour period what most people would regard as an unusually large amount of food?..... Yes No
If you checked no to either a or b, please go to question 9
- c. Has this been as often as twice a week for the last three (3) months?..... Yes No

8. In the last three (3) months, have you often done any of the following in order to avoid gaining weight?

- a. Made yourself vomit? Yes No
- b. Taken more than twice the recommended doses of laxatives?..... Yes No
- c. Fasted (not eaten anything at all for at least 24 hours)?..... Yes No
- d. Exercised for more than an hour, specifically to avoid gaining weight after binge eating? Yes No
- e. If you checked YES to any one of these ways of avoiding gaining weight, were any as often or average, as twice a week? Yes No

9. **Do you ever drink alcohol, including beer and wine?**..... Yes No
if you answered no, go to question 11

10. **Have any of the following happened to you more than once in the last six (6) months?**

- a. You drank alcohol even though a doctor suggested that you stop drinking because of a problem with your health?..... Yes No
- b. You drank alcohol, were high from alcohol, or were hung over while you were working, going to school, or taking care of someone else's children, or other responsibilities?..... Yes No
- c. You missed or were late for work, school, or other activities because you were drinking or hung over?..... Yes No
- d. You had problems getting along with others while drinking?..... Yes No
- e. You drove a car after having several drinks or after drinking too much alcohol?..... Yes No

11. **Do you presently use recreational drugs?**..... Yes No

If yes, please give details: _____

12. **Have you ever used alcohol or drugs more than you do now?**..... Yes No

If yes, please explain to what extent: _____

13. **In the last four (4) weeks have you been bothered by any of the following problems?**..... Yes No

- a. Worrying about your health?..... Yes No
- b. Your weight or how you look?..... Yes No
- c. Little or no sexual desire or pleasure during sex?..... Yes No
- d. Difficulties with your husband/wife or significant other?..... Yes No
- e. The stress of taking care of children, parents, or family?..... Yes No
- f. Stress at work, outside of the home, or school?..... Yes No
- g. Financial problems or worries?..... Yes No
- h. Having no one to turn to when you have a problem?..... Yes No
- i. Something bad that happened recently?..... Yes No
- j. Thinking or dreaming about something terrible that happened to you in the past? (like your house being destroyed, a severe accident, being physically, mentally or sexually abused..)..... Yes No
- k. Learning disability (Dyslexia, ADHD, Math Disability)?..... Yes No

14. **In the last year, have you been hit, slapped, kicked, or otherwise physically hurt by someone, or has anyone forced you to have unwanted sexual acts?**..... Yes No

15. **What is the most stressful thing in your life right now?**

16. **If you checked off any of the problems on this questionnaire so far, 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?**

- a. Not difficult at all
- b. Somewhat difficult
- c. Very difficult
- d. Extremely difficult

