

PATIENT REGISTRATION FORM

Today's Date:				
PATIENT INFORMATION				
Patient's last name:		First:		Middle Initial:
D.O.B:	Age:	SSN (last 4 digits) :	Sex:	Marital Status:
Address:				
City:		State:		Zip:
Home phone:		Work phone:		Cell phone:
Email Address:		Referred by:		
Other family members seen here? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name:				
PARENT/LEGAL GUARDIANS (for patients who are minors or have legal guardians)				
1 st Parent/Legal Guardian name:				
Address (if different):				
D.O.B:	Age:	SSN (last 4 digits) :		
2 nd Parent/Legal Guardian name:				
Address (if different):				
D.O.B:	Age:	SSN (last 4 digits) :		
IF THE INSURED IS NOT THE PATIENT (please complete if applicable)				
*Do NOT complete if we will NOT be billing your insurance company:				
Insured:			D.O.B:	
Employer (if group policy):				
Relationship to patient: <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other (if other, explain below)				
<div style="border-bottom: 1px solid black; width: 100%;"></div> <div style="border-bottom: 1px solid black; width: 100%;"></div>				
COORDINATION OF CARE / RELEASE OF RECORDS				
It is important for your healthcare providers to work together in coordinating your care. Please complete the information below and indicate your approval.				
Primary Care Physician:		Phone:	Fax:	
Psychiatrist/Therapist:		Phone:	Fax:	
For the purposes of continuation of my medical care I give permission for CMPS to contact and/or release copies of my visit notes to the following when requested. Initial: 				
<input type="checkbox"/> Primary Care Physician <input type="checkbox"/> Referring Provider <input type="checkbox"/> Other Clinician: _____ <input type="checkbox"/> No information may be released NOTE: This is not a full medical records access request. That would still require a separate Release of Information (available on our website or at the front desk) to be signed and returned to the Medical Records Department.				

PATIENT REGISTRATION FORM (continued)
Patient's Name _____

REMINDER CALLS

We offer an automated reminder that will contact you two business days ahead of time to remind you of your appointment. Please choose one of the following options:

- ☐ Yes, I want CMPS to send me appointment reminders
- ☐ Phone call with automated message
- ☐ Text message to your cell phone
- ☐ Email message
- ☐ No, I do not want CMPS to send me appointment reminders

IN CASE OF EMERGENCY

Emergency contact name:

Relationship:

Address:

City:

State:

Zip:

Home phone:

Work phone:

Cell phone:

RELEASE OF LIMITED INFORMATION

I give CMPS authorization to leave me a voice message regarding:

- ☐ Appointment Details ☐ Financial/Pay Bill ☐ Prescriptions

If there is anyone whom you give permission to release limited information on your account, please list these names below (including parents/legal guardians if patient is under 18) and specify what information they may access. No other information other than what you list will be released. NOTE: This is not a full medical records access request. If no one else is granted permission to access your account, please state "NONE."

Name:

Relationship:

Phone number:

What info may be released? ☐ Appointment Details ☐ Financial/Pay Bill ☐ Pick up Prescription

Name:

Relationship:

Phone number:

What info may be released? ☐ Appointment Details ☐ Financial/Pay Bill ☐ Pick up Prescription

The above information is true to the best of my knowledge. I authorize you to release any information required to process my claims. I understand that I am financially responsible for any balance not paid by insurance.

Signature of Patient/Guardian:
Date:

AUTHORIZATION FOR TREATMENT, PAYMENT & HEALTHCARE OPERATIONS

By my signature below, and my presence at CMPS, I hereby authorize CMPS to provide mental health care. I authorize Comprehensive MedPsych Systems to release to my insurance company, managed care organizations, state agency/agencies, Health Care Financing Administration, Third Party Administration, and/or Workers' Compensation or its agents any information needed to process my claims and/or determine benefits payable for related services.

If I am entitled to mental health benefits arising out of any insurance policy or from any person or organization who is or may become liable to me to provide such benefits, I hereby assign and authorize payment of such benefits for mental health services to which I am entitled to Comprehensive MedPsych Systems for services rendered to me.

If applicable, I request that payment of Medicare benefits for mental health services be made on my behalf and assign them to Comprehensive MedPsych Systems and authorize submission of the necessary claims for payment. I authorize any holder of medical, mental health, and/or any financial information about me to release to the Health Care Financing Administration, or Medicare intermediaries, or Medicare Carriers any information needed for proper reimbursement.

I understand that Comprehensive MedPsych Systems participates and/or has contracted agreements with selected insurance plans/third party payers. I understand that unless otherwise restricted by a contractual agreement with such plans/third party payers, the entirety of the charges incurred that I agree to will be transferred to the guarantor's responsibility as per the EOB or if the payment is not received from insurance within 60 days. I understand that I will be bound by any conditions of this agreement regarding guarantor/patient responsible charges. I understand that failure to meet my financial responsibilities in a timely manner may result in my account being turned over to a collection agency. I understand that I am responsible for any collection fees, attorneys' fees, and/or court fees that may be involved.

I agree to maintain a current credit card on file at CMPS and that my credit card can be charged for any outstanding balance as per my insurance EOB for deductible and/or co-pay or co-insurance and/or missed appointment fee.

I understand that I must provide Comprehensive MedPsych Systems no less than 2 business days notice to cancel an appointment, and payment of any late cancellation/missed appointment charge will be my sole responsibility. However, if I miss my appointment because I was hospitalized the missed appointment fee will be waived.

I understand that all patient responsible charges are due to prior services rendered.

NOTE: *THE TERMS OF THIS AGREEMENT CANNOT BE CHANGED, DELETED, OR AMENDED.* Unless all terms as written are agreed upon and signed below, you will be unable to be evaluated or treated by any CMPS provider

I agree to the above conditions.

Signature of Patient/Guardian

Date

LATE CANCELLATION/NO SHOW APPOINTMENT POLICY

Mental Health care requires the collaboration effort of both you and your clinician. When you do not come to your scheduled appointment or cancel your appointment without the required 2 business day notice, unless the missed appointment was due to hospitalization, not only do you miss an opportunity for treatment, but you also deny someone else the opportunity as well.

We offer a courtesy reminder via text, email, or voice message to remind you of your appointment, however, you are ultimately responsible for keeping your appointments. **Consequently, late cancellations and no show appointments will be charged a \$100 fee for psychiatry and psychotherapy appointments, and \$300 for psychological or neuropsychological testing appointments. Payment will be expected on or before your next scheduled appointment.**

Insurance companies do not pay for either late cancellations or missed appointments.

THE RESPONSIBILITY IS YOURS.

I HAVE READ AND AGREE TO ABIDE WITH THIS POLICY.

Signature of Patient/Guardian

Date

AUDIO OR VIDEO RECORDING OF ANY SESSION IS FORBIDDEN

According to Florida law and under penalty of Florida law, I agree that neither I nor any other participant in my session(s) will record any audio or video portion of my session without written mutual consent from myself and my provider (and any other participant as applicable). No matter which state I or my provider are in during my treatment session(s), if I or any participant in my session do record any audio or video information during my treatment session(s) without written mutual consent, the session will immediately be terminated (with my obligation to pay the full fee for the session), all future treatment sessions of any kind will be canceled/terminated, and I will be permanently discharged from my provider and all providers in the CMPS company.

I HAVE READ AND AGREE TO ABIDE WITH THIS POLICY.

Signature of Patient/Guardian

Date

ACKNOWLEDGMENT OF RECEIPT OF PATIENT NOTIFICATION OF PRIVACY PRACTICES

I, _____, have been presented with a copy or given information regarding access to a copy of Comprehensive MedPsych Systems' Patient Notification of Privacy Practices, detailing how my information may be used and disclosed as permitted under federal and state law, and I understand the contents of the notification. By law, CMPS is required to obtain your signature indicating you have received this document. Your signature below does not surrender any rights or confidentiality. Any updates to this policy will be posted on our website and in our lobby for review.

Signature of Patient/Guardian

Date



Comprehensive MedPsych Systems

TELEHEALTH INFORMED CONSENT

As a patient receiving mental health services through telehealth methods, I understand that such service is provided by technology (including but not limited to video, phone, text, and email) and in part or in whole does not involve direct, face to face communication.

TECHNOLOGY/EQUIPMENT: If a remote video platform is utilized, then I understand that I will need an installed and working webcam and speakers or headphones. I understand that I will receive an e-mail with a link to open the remote video program and if not previously downloaded, there may be some time necessary to download the program onto my computer before it starts. I understand I will need a PC or Mac or iPad; a Chromebook or iPhone or other cellular phone or other internet enabled device may not work and may not be appropriate.

The quality of the communication depends upon the sophistication and reliability of the telehealth medium used based upon my own internet connection, my provider's internet connection, the program itself, or the program's internet cloud based system. I understand that there could be some miscommunication or lack of communication as a result of technological limitations or unreliability inherent within my or my provider's internet service and platform utilized which are not under the control of myself or my provider.

In the event of disruption of the telehealth service or in the event of an emergency, or for other routine or administrative reasons, it may be necessary to communicate by other means such as direct telephone communication. The following phone numbers will be set up as a backup in the event the telehealth platform cannot be utilized from the start of the scheduled session or at any time after the session begins:

Provider: CMPS

Patient phone number: _____

CONFIDENTIALITY: I understand that other CMPS staff be may present during the session to initiate the connection or if there is a problem only to assure reliable operation of the telehealth system. Such staff will maintain confidentiality of any information under contractual arrangements and/or Federal law and/or State law.

While telehealth services allow for greater convenience in service delivery, there are risks in transmitting information over the internet that include, but are not limited to: breaches of confidentiality, theft of personal information, and disruption of service due to technical difficulties which may not be under the control of either my mental health services provider or myself.

ENVIRONMENT: *It is my responsibility to maintain privacy and a controlled quiet environment on my end of the telehealth communication* which means that there should be not any disruption such as from children, animals, family members, other individuals, or other environmental disruptions (e.g., landscaping, traffic, telephone calls or ringtones, etc.). In the event that such disruption occurs and is deemed by my provider to compromise the quality of the telehealth services he/she is attempting to deliver, I understand that, at my provider's sole discretion, the session will be terminated and the full fee owed for the period of time for which the session was originally scheduled. I understand that a new fee will be obligated to be paid by myself for any rescheduled or future telehealth appointment.

INSURANCE: I understand that telehealth services may or may not be a covered benefit under my insurance plan; if they are covered, any plan co-pay and deductible will apply. The same No-Show and Cancellation policies previously signed and agreed to at the start of treatment remain in effect.

TESTING: If my telehealth session is for the purpose of psychological or neuropsychological evaluation involving testing procedures, I understand that the administration of such procedures via telehealth may not meet standards typically required. As a result, this may decrease the accuracy of test scores, interpretation of test scores, conclusions, diagnoses, and recommendations. Any limitations as to my clinician's confidence in the results will be documented within the written report. I understand I have a right to forgo such psychological or neuropsychological evaluation and schedule an appointment at a later time when my clinician is able to provide the test administration within the office.

I understand that I may dispute any results on the basis of the non-standardized telehealth test administration and such dispute shall be provided in writing and entered into the formal record and attached to the written report as per federal HIPAA law. However, if a re-evaluation is requested or required with test administration within the office of my clinician or any other CMPS clinician, then the full fee for another evaluation will be required which may or may not be covered by my insurance plan.

I hereby attest that any test forms provided to me in the course of the telehealth test administration shall be returned via regular mail via sealed envelope without any copies made or other documentation of the content of the test forms. If I am provided test forms in any electronic format, I hereby attest that I shall destroy or permanently delete these electronic forms without creating any type of copy or documentation as to the content of the forms. I hereby attest that I will not make any copy or recording of any material provided on my computer screen/monitor including the creation of a screenshot or copying and pasting of any information provided on screen.

Any breach of the above conditions will result in the immediate termination of the telehealth psychological or neuropsychological evaluation; it will also be documented within the report generated up to and including providing statements that the entire report is invalidated and cannot be used for diagnostic or treatment planning purposes. If such a breach occurs and any portion or all of the evaluation is terminated or determined to be invalid, then any and all fees provided for payment of the evaluation shall be forfeit and nonrefundable.

DOCUMENTATION: I understand that the documentation my provider writes in relation to any telehealth session will be created and stored in the same EHR system as any note created from a face-to-face appointment/session. Such documentation falls under the same legal, professional, and contractual guidelines as any document stored as the result of a face-to-face appointment/session. No different than any documentation in my record, I understand that I have access to information resulting from the telehealth service to the extent required by State and Federal law.

RIGHT TO WITHDRAW CONSENT: I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time so long as it is provided in writing in accordance with State and/or Federal law without affecting my right to future care or treatment. As long as this consent is in force, telehealth services may be provided to me without the need to sign another consent form.

COMPLIANCE WITH LAW: I understand that telehealth services provided to me must comply with State and Federal (HIPAA) law and I acknowledge that I am aware of such laws. I understand that the reporting requirements (e.g., to law enforcement or a state agency) which may be mandatory under State law are no different than if the service was provided face-to-face as per the Consent Form I originally signed for service.

RECORDING: If my provider provides the telehealth service in the State of Florida, then according to Florida law and under penalty of Florida law, I understand that there will be NO recording of any video or audio information from the telehealth session by myself or my provider or any other participant in my telehealth session(s) without the mutual signed consent of myself and my provider (and any other participant as applicable). If my provider provides telehealth service from Alabama, unless there is mutual consent in writing, I agree that I will not record any video or audio portion of the telehealth session.

I understand that if I do record any portion of the video or audio information without mutual consent, the telehealth session will immediately be terminated, all future treatment sessions of any kind will be canceled/terminated, and I will be discharged from my provider and all CMPS providers with all fees forfeited.

- I have read or had this form read and/or had this form explained to me.
- I have been given ample opportunity to ask questions and my questions have been answered.
- The risks, benefits and any practical alternatives have been discussed in language I understand.
- The alternatives to telehealth consultation have been explained to me, and I am choosing voluntarily to participate in a telehealth consultation.

This document does not replace other agreements, contracts, or documentation of informed consent.

Patient Name

Parent or Legal Guardian (if applicable)

Signature of Patient, Parent or Legal Guardian

Date

Patient Date of Birth

Instructions: Please complete the following questionnaires (PHQ-9; GAD-7; AUDIT-C; Tobacco)

Name _____ Date _____

Provider _____ DOB _____

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Over the <u>last 2 weeks</u> , how often have you been bothered by any of the following problems?		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

	add columns:			
	TOTAL:			

10. 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 _____

ANXIETY QUESTIONNAIRE (GAD-7)

Over the <u>last 2 weeks</u> , how often have you been bothered by any of the following problems?		Not at All	Several Days	More than half the days	Nearly every day
1	Feeling nervous, anxious, or on edge	0	1	2	3
2	Not being able to stop or control worrying	0	1	2	3
3	Worrying too much about different things	0	1	2	3
4	Trouble relaxing	0	1	2	3
5	Being so restless that it is hard to sit still	0	1	2	3
6	Becoming easily annoyed or irritated	0	1	2	3
7	Feeling afraid as if something awful might happen	0	1	2	3
TOTAL:					
8.. If you checked off <i>any</i> problems, how <i>difficult</i> 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 _____			

Please answer the following question:

Do you use any type of tobacco: Yes No

AUDIT C

Name: _____ Date: _____

1: How often did you have a drink containing alcohol in the past year?	
Never	0
Monthly or less	1
Two to four times a month	2
Two to three times a week	3
Four or more times a week	4
2: How many drinks did you have on a typical day when you were drinking in the past year?	
None, I do not drink	0
1 or 2	0
3 or 4	1
5 or 6	2
7 to 9	3
10 or more	4
3: How often did you have six or more drinks on one occasion in the past year?	
Never	0
Less than monthly	1
Monthly	2
Weekly	3
Daily or almost daily	4

Total _____

ADULT INITIAL EVALUATION: Patient Form

Date: _____

Patient: _____ DOB: _____ Referred by: _____

Name of Person completing this form if not patient: _____

Briefly describe the events that led to this appointment.

Have there been any previous mental health contacts? If yes, list these contacts and approximate dates of treatment (include hospitalization dates). List any past psychiatric medications.

Please check any of the following symptoms or complaints that apply to your situation. Add comments if necessary:

- ☐ Sad Mood _____
- ☐ Low Energy/Fatigue _____
- ☐ Hopelessness _____
- ☐ Worthlessness _____
- ☐ Crying Spells _____
- ☐ Guilt _____
- ☐ Decreased Motivation _____
- ☐ Loss of Interest in Usual Activities _____
- ☐ Irritability _____
- ☐ Hyperactivity _____
- ☐ Impulsiveness _____
- ☐ Elevated Mood _____
- ☐ Racing thoughts _____

Patient: _____ Date: _____

Patient Form Page 2

- ☐ Concentration/Memory Difficulties _____
- ☐ Increased Sexual Interest _____
- ☐ Decreased Sexual Interest _____
- ☐ Decreased Appetite _____
- ☐ Increased Appetite _____
- ☐ Difficulty Falling Asleep _____
- ☐ Early Morning Awakening _____
- ☐ Difficulty Staying Asleep _____
- ☐ Excessive Sleeping _____
- ☐ Suicidal thoughts _____
- ☐ Thoughts of Harming Others _____
- ☐ Anxious/Worried _____
- ☐ Panic Attacks _____
- ☐ Fear of Leaving the House _____
- ☐ Fear of Driving _____
- ☐ Fear of Specific Situations or Things _____
- ☐ Fear of Embarrassing Oneself in Public _____
- ☐ Intruding, Uncomfortable, Upsetting Thoughts _____
- ☐ Repetitive Thoughts or Behaviors _____
- ☐ Excessively Orderly and Perfectionistic _____
- ☐ Periods of "Lost" Time _____
- ☐ Excessive Anger / Aggressiveness _____
- ☐ Difficulty Trusting Others _____
- ☐ Binging/Purging _____
- ☐ Rebellious/Defiant _____
- ☐ Victim of Abuse or Trauma: _____
 - ☐ Emotional _____
 - ☐ Sexual _____
 - ☐ Physical _____
- ☐ Offender of abuse: _____
 - ☐ Emotional _____
 - ☐ Sexual _____
 - ☐ Physical _____

Do any of the people in your current living situation have a mental health, alcohol or drug problem? If yes, please list and describe.

Use the table below to describe the people in your current living situation.

Name	Relation to yourself	Age	Education/ Occupation	Personal Style

Describe your current employment and financial situation:

Describe any relevant legal issues:

Describe any other relevant stressors:

Do any of the people in your family of origin currently or in the past have a history of mental health, alcohol, or drug problems? If yes, please list and describe.

Patient: _____ Date: _____

Patient Form Page 4

Use the table below to describe the people in your family of origin.

Name	Relation to yourself	Age	Education/ Occupation	Personal Style

Please check any of the following medical issues that apply to your situation. Add comments if necessary:

- ☐ Blood Pressure Problems _____
- ☐ Diabetes _____
- ☐ Thyroid _____
- ☐ Heart Lungs _____
- ☐ Kidney _____
- ☐ Stomach _____
- ☐ Seizures _____
- ☐ Headaches _____
- ☐ Other _____

Who is your Primary Care Doctor? _____

Date of your most recent physical? _____

Date of your most recent blood work? _____

Ever had EEG, CT, MRI, of the head? _____

Any abnormal findings?

List all current medications:

Allergies (include medication allergies): _____

Please complete the following table and answer the questions below. Add comments if necessary:

Substance Use:

Substance	Age of First Use	Most Recent Pattern of use and Duration <i>How much you use, how often, and do you need more or less to get the same effect?</i>	Date of last use and time	History of Withdrawal <i>Describe symptoms</i>	Method of Use <i>(oral, smoked, snort, IV, etc)</i>
Alcohol					
Sedatives/Barbituates					
Heroin (Opioids)					
Cocaine					
Other Stimulants					
Marijuana					
Halucinagenics					
Nicotine					
Caffeine					
Meth/Amphetamines					
Inhalants					
Benzos					
Synthetics (ex. PCP/ecstasy/spice/flakka, bath salts)					
Rx Medications					
Over-the-Counter Drugs					
Other					

What are your triggers for use?

☐ No ☐ Yes Someone in the biological family has or has had a serious substance abuse problem.

☐ No ☐ Yes In the past 2 years, there has been 1 or more episodes of memory loss due to substance abuse.

☐ No ☐ Yes There are personality changes due to the use of substances.

☐ No ☐ Yes In the past 5 years, there has been one or more arrest with a B.A.L. of .16% or higher.

☐ No ☐ Yes Someone close to you thinks you may have a serious substance use problem.

☐ No ☐ Yes In the past year there has been an out of control experience due to substance use.

☐ No ☐ Yes There is a history of serious problems with the use of substances.

☐ No ☐ Yes There is a history of substance abuse treatment (may include 12-step program).

Comments

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