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? ☐ Yes ☐ No		If yes, name:			
PARENT/LEGAL GUARDIANS (for patients who are minors or have legal guardians)					
1st Parent/Legal Guardian name:					
Address (if different):					
D.O.B:	Age:	SSN (last 4 digits) :			
2nd 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: ☐ Spouse ☐ Child ☐ Other (if other, explain below) ____ ____					

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: ___________ ☐ Primary Care Physician ☐ Referring Provider ☐ Other Clinician: ___________ ☐ 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 Carries 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***

PHQ-9: Modified for Teens

Name: __________________________ **Clinician:** _______________________ **Date:** ________

Instructions: How often have you been bothered by each of the following symptoms during the past **two weeks**? For each symptom put an **"X"** in the box beneath the answer that best describes how you have been feeling.

	(0) **Not At All**	*(1)* **Several Days**	*(2)* **More Than Half the Days**	*(3)* **Nearly Every Day**
1. Feeling down, depressed, irritable, or hopeless?	☐	☐	☐	☐
2. Little interest or pleasure in doing things?	☐	☐	☐	☐
3. Trouble falling asleep, staying asleep, or sleeping too much?	☐	☐	☐	☐
4. Poor appetite, weight loss, or overeating?	☐	☐	☐	☐
5. Feeling tired, or having little energy?	☐	☐	☐	☐
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?	☐	☐	☐	☐
7. Trouble concentrating on things like school work, reading, or watching TV?	☐	☐	☐	☐
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?	☐	☐	☐	☐
9. Thoughts that you would be better off dead, or of hurting yourself in some way?	☐	☐	☐	☐

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?

[ ] Yes [ ] No

If you are experiencing any of the problems on this form, 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

Has there been a time in the **past month** when you have had serious thoughts about ending your life?

[ ] Yes [ ] No

Have you **EVER**, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?

[ ] Yes [ ] No

***If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your Health Care Clinician, go to a hospital emergency room or call 911.*

Office use only: **Severity score:** ____________

Modified with permission by the GLAD-PC team from the PHQ-9 (Spitzer, Williams, & Kroenke, 1999), Revised PHQ-A (Johnson, 2002), and the CDS (DISC Development Group, 2000)

CHILD AND ADOLESCENT EVALUATION: PATIENT FORM

Name: ______________________ Sex: ______ Birthdate: ________ Provider: ______________

Evaluation date: ______________________ Form filled out by: ______________________

Referred by: ______________________ Persons present for evaluation: ______________________

Briefly describe the events that led to this appointment.

What concerns you most about your child?

What are your goals for the evaluation?

Have you seen other professionals about these problems? If yes, list these contacts and approximate dates of evaluation and treatment (include hospitalization dates).

Please list past and current medications and approximate doses and dates of treatment.

OFFICE USE ONLY

CHILD AND ADOLESCENT EVALUATION: PATIENT FORM

Patient: ______________ Date: ______________ Provider: ______________

OFFICE USE ONLY

Developmental History

Pregnancy /neonatal/ infancy:

Were there complications with the pregnancy or your child's delivery (for instance, medications, prematurity, fetal distress, low Apgars, C-section)? Were there any medical problems in the first two years of life?

Developmental milestones and concerns:

Did/does your child have problems with the following developmental milestones? Please note the dates you had concerns about the problem.

Feeding concerns? ______________

Breast Feed? How long? ______________

Physical growth problems? ______________

Colic? ______________

Sleep habits? ______________

Sleep through the night? ______________

Sleeping alone? ______________

Age of walking? ______________

Clumsiness? ______________

Age of first words, first sentences? ______________

Other language concerns? ______________

Age of bowel training? Current Soiling? ______________

Age of bladder training? Current wetting? ______________

Hygiene concerns? ______________

Problems separating from parents? ______________

Past and current peer relations? ______________

What do you see as your child's strengths and weaknesses?

Patient: ____________ Date: ____________ Provider: ____________

OFFICE USE ONLY

School History

What is your child's grade and school?

What other schools has he/she attended?

Has your child been in special education? Have there been learning problems? Give details of problems and supports.

Do you have concerns about the school program?

Has there been psychological testing? When? Results? Bring to the evaluation if available.

What is your child's attitude toward school?

What are your hopes for your child's educational attainment and vocational future?

Patient: ______________________ Date: ______________________ Provider: ______________________

OFFICE USE ONLY

Social History

List the names, ages, and occupations/grades of family members in the current household.

List immediate relatives (biological or related by marriage, parents or siblings) or other primary caretakers (sitters, day care) of the child outside the primary home. Has there been any significant history of problems with caretakers, such as abuse or neglect?

Are there any particular stresses or recent changes in the family such as job changes, financial problems, school changes, health problems, marriage or divorce, violence, or substance abuse?

Who is responsible for disciplining? What methods work or haven't worked? Do caregivers/parents agree on discipline? Is there allowance? Are there chores?

How well I does your child get along

with siblings? ______________________

with peers? ______________________

with parents? ______________________

by himself/herself? ______________________

What are family activities or mealtimes like? Does your child have other activities or hobbies? Favorite TV or movies?

CHILD AND ADOLESCENT EVALUATION: PATIENT FORM

Patient: ____________ Date: ____________ Provider: ____________

OFFICE USE ONLY

Medical History

Child's local physician ____________

address ____________

phone ____________

date of last physical exam ____________

Has your child seen a specialist, such as a neurologist, etc.? Please list names, approximate dates, and reasons for consultation.

____

Allergies (environmental, food, and/or medication related)

____

Current medicines, or any medicine ever taken over 6 months duration (include over the counter or "natural" medicines).

____

Medical concerns (give details if applicable)

- ☐ Asthma or breathing problems
- ☐ Headaches
- ☐ Gastrointestinal concerns
- ☐ Head injury history
- ☐ Seizures
- ☐ Ear infections
- ☐ Frequent or recent strep infection
- ☐ Heart murmur or problems
- ☐ Hospitalizations or surgeries
- ☐ Hearing loss (testing done?)
- ☐ Vision problems
- ☐ Onset of puberty or menses
- ☐ Sexual activity
- ☐ Other medical concerns

____

Patient: ______________ Date: ______________ Provider: ______________

Family History

OFFICE USE ONLY

Please identify if there is a history of the following problems in the **child's genetic or natural family**, and indicate briefly the problem and relative (for example, seizures in a maternal aunt).

Alcohol or drug problems in family members

Eating problems in family members

ADHD or school behavior problems in family members

Conduct problems or court involvement in family members

Mental retardation, learning, disabilities, or other developmental problems

Mood problems, including suicide, depression, or manic-depressive illness, treated or untreated in family members

Anxiety and panic problems in family members

Schizophrenia in family members ______________

Neurologic problems such as seizures, or migraines

Tics or Tourette disorder ______________

Thyroid problems in family members ______________

Genetic syndromes in family members ______________

Cardiac or other medical problems in family members

CHILD AND ADOLESCENT EVALUATION: PATIENT FORM

Patient: ____________________ Date: ____________________ Provider: ____________________

OFFICE USE ONLY

PLEASE CIRCLE AND COMMENT AS APPROPRIATE:

- ☐ careless / poor attention to details
- ☐ difficulty sustaining attention
- ☐ doesn't listen
- ☐ doesn't follow through with requests
- ☐ difficulty organizing
- ☐ avoids effortful tasks
- ☐ loses necessary things
- ☐ easily distracted
- ☐ forgetful in daily activities
- ☐ fidgets
- ☐ leaves seat
- ☐ runs about / subjectively restless
- ☐ difficulty playing quietly
- ☐ "On the go"/ "motor driven"
- ☐ excessive talk
- ☐ blurts out answers
- ☐ difficulty waiting turn
- ☐ interrupts/intrudes

Where are these problems present, in the home, in the school, or in other settings?
Comments:

stealing in the home or out of home
lying
truancy/runaway
violence in the family
violence at school
violence in the community
fire setting or fireplay
cruelty to animals
legal involvement with juvenile services
inappropriate sexual interests and behavior
lack of conscience
threats of violence
exceptional negativity to rules

Comments:

alcohol use
marijuana use
cigarette use
other substance use

Comments:

CHILD AND ADOLESCENT EVALUATION: PATIENT FORM

Patient: ______________________ Date: ______________________ Provider: ______________________

PLEASE CIRCLE AND COMMENT AS APPROPRIATE:

OFFICE USE ONLY

expresses depression or hopelessness or low self esteem

can be irritable or giddy or elated inappropriately

hypersexual or loss of other inhibitions

mood swings (circle period of change MINUTES, HOURS, DAYS, WEEKS, or MONTHS)

moods change without reason

lack of interest in friends or normal activities

poor sleep or excessive sleep

poor eating or excessive eating or concerns over weight changes or dieting

binging with or without purging (self induced vomiting)

suicidal talk or acts of self harm or mutilation

Comments:

____

____

____

____

____

____

school refusal or excessive absences

anxiety at bedtime or in the night / refusal to sleep alone

fears of harm to family members

complaints of physical symptoms such as headache or stomach ache

specific phobias (heights, spiders, etc.)

sudden feelings of panic

refusal to speak in public, or refusal to go out in public

history of trauma (abuse, accident, etc.)

nail biting, thumb sucking, teeth grinding, hair pulling, skin picking

excessive hand washing, or repetitive touching, or checking, or other "rituals"

overconcern regarding germs, illnesses, contamination by dirt, or other obsessive thoughts

overly perfectionistic

Comments:

____

____

____

____

____

CHILD AND ADOLESCENT EVALUATION: PATIENT FORM

Patient: ____________ Date: ____________ Provider: ____________

PLEASE CIRCLE AND COMMENT AS APPROPRIATE:

OFFICE USE ONLY

tics or twitches of the mouth, eyes, facial muscles, or arms and legs

head banging or rocking

other repetitive behaviors causing self injury (biting, scratching, etc.)

other repetitive movements such as jumping or arm/hand flapping or spinning

lack of affection (doesn't seek out or provide comfort)

little need for reassurance in a strange situation, or little stranger anxiety

poor peer relations/ no real friends

problems understanding feelings of others during interactions

distress over changes in routine

unusual toy or play interests (collections, string, line up or take apart toys rather than play)

restricted conversational interests (dinosaurs or specific topics to the exclusion of other topics)

hoarding food or other objects

Comments:

odd thinking or peculiar ideas

difficulty discerning what is real vs. normal fantasy play

paranoid thinking

hearing voices

seeing things not there

periods of odd sensations or loss of memory for a period of time

PLEASE ALSO COMMENT BELOW IF YOU HAVE OTHER CONCERNS NOT RAISED IN THE PREVIOUS SEVERAL PAGES

Comments: