2130 South 17th Street Suite 100 Lincoln NE 68502
Phone: 402-454-7454 Fax: 1-402-513-6547 *(the 1 must be dialed when faxing to our office)*
Email: admin@genesispsychiatricgroup.com

Patient Registration Form

The providers and staff at Genesis Psychiatric Group welcome you to our practice. **This form along with the Patient Health Questionnaire must be filled out completely** prior to the scheduling of an appointment. We look forward to seeing you soon.

Patient Information

Full Name ______________________________ DOB ____________

SSN ______________________ Gender __________ Race ______________

Martial Status ____________ Spouse's Name ______________________

Guardianship: Does the patient have a guardian? **Y / N**

If applicable: Caseworker name and phone number ______________________

Guardian name and phone number______________________

Address ______________________ City __________ State ____ Zip _____

Mobile Phone ____________ Home Ph ____________ Work Ph ____________

Email address for appointment reminders ______________________

Best Contact: *Circle One*: Cell Phone / Home Phone / Work Phone / Other:______________

Emergency Contact

Emergency contact full name ________________ Relationship ____________

Cellular Phone (____)__________ Home Ph ____________ Work Ph ____________

Person Financially Responsible If same as patient check here _____ and skip to Insurance Information

Full Name ________________ DOB ______ Relationship to patient __________

Address ________________ City __________ State ____ Zip ________

SSN ______________ Employer ________________ Work Phone ________

Home Phone __________ Cellular Phone __________ Email ________________

Insurance Information *This section must be complete.* If self-pay/no insurance check here _____

Primary Insurance Company ________________ Phone Number ____________

Policy Number ______________________ Group Number ______________

Subscriber's Information:

Name ________________ Address ______________________

DOB ________ SSN ____________ Relationship to Patient ______________

Employer ______________________ Policy Holder's Phone ______________

Do you have a co-payment? **Y / N**

If you have Medicare: Are you a Veteran? ______ Do you have a Federal Black Lung Card? ______

Secondary Insurance Company ______________________________ Phone Number _____________________

Policy Number ________________________________ Group Number ________________________________

Policy Holder's Name _______________________________ DOB _____________ Phone ________________

Address ____

Additional Insurance Coverage:____

Coordination of Care/Referral Information

Primary Care Provider (PCP) ____

May we release information to your PCP for coordination of care purposes? **Y / N**

If no, please explain:

____

If other than your PCP, whom may we thank for referring you to our office? _______________________________

Authorization for Medical Treatment, Statement of Financial Responsibility, Notice of Privacy Practices, Patient Rights and Responsibilities, and Magellan Member Rights and Responsibilities (if applicable)

Authorization for Medical Treatment – I authorize the healthcare providers and/or designees in charge of my medical care to administer any treatment as may be necessary or advisable in my diagnosis and treatment at Genesis Psychiatric Group (Practice). This authorization includes, but is not limited to, routine diagnostic procedures, psychotherapy, lab test, and the use of prescription medication. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to results of treatment received at this Practice. Initial __________

Financial Agreement – I understand that I am financially responsible to the Practice as the patient, parent, guardian, conservator, or insured for all charges not covered by my insurance plan. The Practice will submit insurance claims on my behalf, however, I am responsible for all deductibles, co-insurance, out-of-pocket expenses, or any charges not covered by my insurance. My estimated share of cost will be due and collected at the time of service. In the event that payment cannot be made, a statement will be mailed and payable in 10 days of receipt. After 60 days, any unpaid balances may be turned over to a collection agency. Initial _________

Insurance Release of Information/Assignment of Benefits – I authorize Genesis Psychiatric Group to release to my Medicare carrier or the Insurance Plan listed previously, any medical information needed for authorization or payment of my insurance claim. I also authorize payments directly to this Practice for my health benefits. I understand that I am responsible for all pre-authorization requirements by my insurance. Initial __________

Notice of Privacy Practices – I have been given the opportunity to review the Practice's Notice of Privacy Practices for Protected Health Information. I understand that the Practice may change the Notice of Privacy Practices at any time and that I may obtain a current copy at the Practice during operating hours. Initial _________

Patient Rights and Responsibilities – I have been given the opportunity to review the Practice's Patient Rights and Responsibilities. Such Rights and Responsibilities may be changed at any time and I may obtain a current copy from the Practice during operating hours. Initial ________

Patient Signature ____ **Date**________________________

***If Parent/Guardian/Guarantor, please print name here** ____

***Parent/Guardian/Guarantor Signature** _________________________________ **Date** __________________

<u>**Genesis Psychiatric Group Patient Health Questionnaire**</u>

Patient Name: ____ Date: __________________________

Date of Birth: _________/_________/_________ Current Height: ____________ Current Weight:____________

Who referred you to our office? ____

Name of the Genesis provider that you would like to see: ____

What is the patient's current symptoms or concerns?

____

____

Please list <u>**ALL**</u> of the patient's current daily medications and dosages that are being taken as well as any side effects.
(Please attach a medication list if necessary)

____

____

____

Which Pharmacy do you prefer?

____

<u>**Past Psychiatric History:**</u>

Has the patient seen a psychiatric medication provider in the past? **Y / N**

If so please list which provider was seen and when they were last seen?

____

____

Has the patient seen a therapist, counselor, or psychologist in the past? **Y / N**

If so please list which provider was seen and when were they last seen?

____

____

Has the patient been hospitalized for psychiatric concerns or gone to treatment in the past? **Y / N**

If so please list when and where.

____

____

Please list <u>**ALL**</u> previous psychiatric medications taken and their effects.

____

____

____

Is there any history of mental health issues or substance abuse in the patient's immediate family? **Y / N**

If so, who and what? Please list any meds that you are aware they were/are taking.

____

____

Medical History:

Who is the patient's Primary Care Provider/Family Physician? When did they last see them?

____

Can we release information to the PCP for coordination of care purposes? **Y / N**

If no, please explain why:

____
____

Are there any allergies to medication, food or environment? **Y / N**

If so to what and the reaction experienced?

____
____
____

Does the patient have any of the following chronic health conditions (***please circle***)?

Asthma Seizures Diabetes High Blood Pressure Chronic Pain

Thyroid Cardiac Headaches High Cholesterol

Other:

____

Please list any surgeries or hospitalizations:

____
____
____

Has the patient had a sleep study? **Y / N**

If so, what were the results?

____

Females only:

Is the patient pregnant? **Y / N** If yes, who is the provider? ____

How many pregnancies? _____________ How many births? _____________

Are they currently taking Birth Control? **Y / N** If so, what type? ____________________________________

Social History:

Where was the patient born? ___________________________Where were they raised? __________________________

Who was in the patient's family while growing up (who raised patient, parental separations or divorces, how many siblings and ages)?

____

____

____

How long has the patient lived at their current address? ____

Does the patient live alone or with others? If so, who and their relationship to the patient?

____

____

____

Is the patient currently married? **Y / N**

If so, how long?

____

Previous marriages? **Y / N**

Children? **Y / N**

If so, please list sex, name, and age.

____

____

____

Does the patient have any Religious or spiritual preference? **Y / N**

If so, what is it? ____

Is the patient enrolled in school? **Y / N**

If so, where and what grade? ____

Highest level of education completed? ____

Does the patient work? **Y / N**

If so, where and what type of work & length of employment?

____

____

Health Practices/Habits:

Does the patient drink alcohol? **Y / N**

If so, how often and how much? ____

Does the patient have previous issues with alcohol causing problems with family/friends/work/school/legal? **Y / N**

If so, when and type of issues? ____

Drug use? **Y / N**

If so, type and frequency? ____

Does the patient have previous issues with drugs causing problems with family/friends/work/school/legal? **Y / N**

If so, when and type of issues?

____

____

Tobacco use? **Y / N** What kind and how much used on daily basis?_________________________________

Previous tobacco use? **Y / N** What/when did they quit using? ____

Other Pertinent Info:

Does the patient have a history of trauma or abuse? **Y** / **N**

If so, please specify (*circle*) as **child**, **adult**, or **both**

Please specify which type of trauma/abuse (*circle*) **physical**, **emotional**, **sexual abuse**, **domestic violence**?

Other ____

Does the patient have current or past legal issues/charges? **Y** / **N**

If so, please list.

____

____

Does the patient have past or current CPS involvement? **Y** / **N**

If so, please indicate when and case worker name.

____

____

Does the patient you have a history of disability? **Y** / **N**

For mental health or medical? **Y** / **N** For how long? _________________________________

Is the patient his or her own legal guardian? **Y** / **N**

If not please list guardian name and phone number.

____

What are your or the patients treatment goals?

____

Thank you for your time in completing our paperwork.