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Patient Registration Form - Telehealth

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 _____

Address _____ City _____ State _____ Zip _____

Contact Name if Patient is a minor _____ Relationship _____

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 _____

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

If applicable: Caseworker name and phone number _____

Guardian name and phone number _____

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** ***the co-payment or co-insurance is due at the time of the appointment***

Secondary Insurance Company _____ Phone Number _____

Policy Number _____ Group Number _____

Policy Holder's Name _____ DOB _____ Phone _____

Address _____

Additional Insurance Coverage _____

Telehealth Location/Coordination of Care/Referral Information

Hospital name or location for your appointment _____

Primary Care Provider (PCP) _____

Can we release information to your PCP for coordination of care purposes? _____

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, Member Rights and Responsibilities, and No-Show Policy:

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.

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.

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.

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.

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.

Telemedicine Consent – I agree to receive health care services as a telemedicine service. I understand that the health care practitioner is at a different location from me. The practitioner is located in Lincoln, NE and is associated with Genesis Psychiatric Group. I hereby consent to the use of telemedicine services and understand that the consulting provider will be at a different location from me. I can decline telemedicine services at any time without affecting my right to future care or treatment and any program benefits to which I would otherwise be entitled cannot be taken away. Video or Audio during the consultation will NOT be recorded. The same confidentiality protections that apply to my other medical care also apply to the telemedicine service. *Initial* _____

NO SHOW APPOINTMENTS- I have been provided a copy of the clinic's Appointment No-Show policy and understand that I am responsible for keeping my appointments and providing at least 24 hours notice should I need to reschedule. *Initial* _____

Patient Signature _____ **Date** _____

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

***Parent/Guardian/Guarantor Signature** _____ **Date** _____

Genesis Psychiatric Group Patient Health Questionnaire

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 **ALL** of the patient's current daily medications and dosages that are being taken as well as any side effects.
Please list the medications that are currently being taken on this form and bring a written list of medications to the first appointment. You may obtain a list of medications from your pharmacy.

*On the day of your appointment you **MUST BRING A LIST THAT INCLUDES THE NAME OF THE MEDICATION, DOSE, AND HOW THE MEDICATION IS TAKEN.***

Which Pharmacy do you prefer?

Past Psychiatric History:

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 **ALL** 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.