



## CONSENT FOR CARE AND TREATMENT

Please read the following information carefully. It is provided to explain our professional services and business policies.

### PROFESSIONAL SERVICES

Psychiatric and psychological services include such things as consultation, medication management, and various types of psychotherapy. The recommended course of treatment is individualized for each patient. These treatments have benefits and risks. Discussing your emotions can cause uncomfortable feelings, but this can also lead to improvements in various aspects of your life. Likewise, medications that are recommended to you will have risks and benefits that will be discussed at the onset of their use.

### TELEHEALTH

At the discretion of your provider, and in accordance with federal and state regulations, some of your services may be rendered by telehealth (secure video consultation). If you choose to receive this service, you must be physically located in the state of Indiana at the time the service is rendered.

### APPOINTMENTS

Initial appointments are scheduled for 60-90 minutes. Follow up appointments are individually scheduled to the needs of the patient and typically last 15 to 60 minutes.

### COMMUNICATION WITH YOUR PROVIDER

Please call our office at the number listed below with any questions about your treatment plan or medications. Your provider is often not immediately available. At times, you may need to leave a voice message. Your provider will make every effort to return your call promptly, excluding weekends and holidays. Requests for medication refills will be submitted to the pharmacy during normal business hours, so please plan appropriately. If it is an emergency, please call 911, go to the nearest emergency room, or call the local Crisis and Suicide Hotline at 317-251-7575.

If you choose to communicate with your provider by email through the contact page of [www.neighborhoodpsych.com](http://www.neighborhoodpsych.com), please understand that you are utilizing a form of communication that is not HIPAA compliant and the privacy of content you include cannot be guaranteed. We suggest you leave voicemails to maximize your privacy.

### Referral Disclosure

During your treatment, there may be instances in which you are referred to other providers for certain services. Some common examples include labs, EKGs, imaging, therapy, or general medical concerns. The State of Indiana requires us to notify you of the following information regarding referrals:

- That an out of network provider may be called upon to render health care items or services to you during treatment.
- The out of network provider is not bound by the payment provisions that apply to health care items or services rendered by a network provider under your health plan.
- You may contact your health plan before receiving health care items or services rendered by an out of network provider to obtain a list of network providers that may render the health care items or services and for additional assistance.



I, the undersigned, do hereby give consent to Neighborhood Psychiatry, P.C. to provide evaluation and

treatment to  SELF OR  OTHER: \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient (if other than self)

**FINANCIAL POLICY & INSURANCE REIMBURSEMENT**

It is the policy of Neighborhood Psychiatry, P.C. to request payment, in full, at the time of service. Cash, personal checks, and credit cards are the accepted forms of payment. We do not currently accept or process insurance. At your request, you will receive a billing statement listing the relevant information that is usually required by insurances companies for reimbursement. You may seek reimbursement from your insurance company at your discretion.

- Missed appointments and appointments cancelled less than 24 business hours in advance are subject to a charge equal to 100% of the planned service fee.
- The patient/doctor relationship may be terminated if there are 2 or more no-shows in 365 days.
- The patient may request a statement of all charges and payments at any time.
- A fee of \$25 will be assessed for any returned checks due to insufficient funds. Should the accounts be sent to collections, the patient is responsible for any associated fees, including legal.
- In order to be eligible for Telehealth the patient must keep a valid credit card on file with Neighborhood Psychiatry.

I, the undersigned, do hereby give agree to the above financial policy of Neighborhood Psychiatry, P.C.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**APPOINTMENT REMINDER PREFERENCE**

I prefer to receive automated appointment reminders in the following way:

Text       do NOT send me appointment reminders       Telephone (may leave voicemail)

To the following phone number: \_\_\_\_\_

**RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I am a patient, or the parent or legal guardian of a patient, of Neighborhood Psychiatry P.C. I hereby acknowledge receipt of Notice of Privacy Practices (also located at [www.neighborhoodpsych.com](http://www.neighborhoodpsych.com))

Name: (print) \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

\_\_\_\_\_  
Relationship to Patient (if other than self)



## HEALTH QUESTIONNAIRE

Please fill out this questionnaire prior to your first appointment. Doing so will allow us to get important information quickly as well as allow us to use your time more efficiently during your scheduled appointment. The information you provide will be kept confidential.

### Patient Information:

Name: \_\_\_\_\_

Address: Street \_\_\_\_\_

City \_\_\_\_\_ ST \_\_\_\_\_ Zip Code \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Telephone: Cell \_\_\_\_\_ Other \_\_\_\_\_

Email Address: \_\_\_\_\_

How did you hear about Neighborhood Psychiatry? \_\_\_\_\_

### Emergency Contact:

Please list someone other than yourself.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Telephone: \_\_\_\_\_

### Marital History:

Relationship status: Single Married Divorced Separated Widowed Domestic Partnership

If married, length of marriage: \_\_\_\_ Spouse's Name: \_\_\_\_\_

Number of previous Marriages: \_\_\_\_ Lengths of prior marriages: \_\_\_\_\_

Reason(s) for divorce: \_\_\_\_\_

### Educational History:

Highest level of education completed: \_\_\_\_\_

### Occupational History:

Current employer: \_\_\_\_\_

Length of employment: \_\_\_\_ Type of Work: \_\_\_\_\_

### General Medical History

List any allergies or medication intolerances you have:

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List all medications you are currently taking, when you take it and for what reason.

Medication	time of day	Reason for medication
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list any current or ongoing medical conditions for which you are being treated:

\_\_\_\_\_  
\_\_\_\_\_

List the name, specialty and phone number of any doctors you are currently seeing:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List any surgeries you have had in the past:

Surgery	Hospital	Date	Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List any other general medical hospitalizations you have had:

Reason	Date
_____	_____
_____	_____
_____	_____

**Mental Health History**

Briefly describe the nature of the problem for which you are seeking help:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



Please list the mental health professionals you have seen in the past (psychiatrists, psychologists, social workers, therapists, counselors):

Name	Locations	Dates	Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list any past psychiatric hospitalizations/partial programs you have been admitted:

Hospital	Date	Reason for treatment
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list any psychiatric medications you have taken in the past

Medication	Date	Reason for medication
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please indicate if there are any issues from your childhood/adolescence that you feel may be of significance (e.g. illnesses, school problems, parents' divorce, family conflict, history of any type of abuse, etc.)

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**Substance Use History**

Do you use tobacco or nicotine? \_\_\_ No \_\_\_ Yes, if so, how much per day? \_\_\_\_\_

Do you use caffeine? \_\_\_ No \_\_\_ Yes, if so, how much per day? \_\_\_\_\_



Please describe your alcohol use:

Type of alcohol	Amount	How often
_____		
_____		

Please list any current or past use of other types of drugs:

Drug	Amount used	How often	Last used
_____			
_____			
_____			

Have you ever been diagnosed with or treated for a substance use problem?

\_\_\_\_ No    \_\_\_\_ Yes    If so, where and when?

\_\_\_\_\_

\_\_\_\_\_

**Family History** (Psychiatric, substance abuse and medical history)

Mother \_\_\_\_\_

Father \_\_\_\_\_

Siblings \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Children:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Others: (grandparents, cousins etc.)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_