CONSENT FOR CARE AND TREATMENT

Please read the following information carefully. It is provided to you to briefly 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 associated with their use that will be discussed at the onset of their use. At times, we may recommend treatments that we are not able to provide such as psychological testing or laboratory studies, for example. We may recommend other providers for those services, but you are not obligated to use those specific providers.

APPOINTMENTS

Initial appointments are scheduled for 60 minutes. Follow up appointments are individually schedule to the needs of the patient and typically last 20 to 45 minutes.

FINANCIAL POLICY

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.

_____ 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.

_____ I 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, I am responsible for any associated fees, including legal.

_____ I agree to abide by the financial policy of Neighborhood Psychiatry, P.C.

INSURANCE REIMBURSEMENT

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.

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. Typically, some basic information about the nature of your call will be taken and your provider will return your call as soon as possible. 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.

*It is not appropriate to contact your provider with clinical questions via email due to its unsecure nature and because we may not check it regularly. If there is an emergency, please call 911, go to the nearest emergency room, or call the local Crisis and Suicide Hotline at 317-251-7575.

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

treatment to _____

_____

Signature Date

_____

Relationship to Patient

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: _____

_____

Signature Date

CURRENT MEDICATIONS

To assist Neighborhood Psychiatry in fully understanding the extent of my current medications, I authorize them to electronically query the available pharmacy databases to assist in compiling information such as a list of medications, doses, frequencies, quantities and other information.

_____

Signature Date

HEALTH QUESTIONAIRE

Please fill out this questionnaire prior to you 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: Home _____Work _____ Cell _____

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: _____ Spouses Name:_____

Number of previous Marriages: _____ Lengths of prior marriages: _____

Reason(s) for divorce: _____

Educational History:

Highest level of education completed:_____

Anything interesting or unique about your educational background? _____

_____

Occupational History:

Current employer:_____

Length of employment: _____ Type of Work: _____

Previous Job History:

Employer	Type of Job	From	To	Reason for change?

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

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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

_____

_____

_____

_____

In the space below, please indicate if there are any issues from your childhood or adolescence which you feel may be of significance (e.g. childhood illness, school problems, parents' divorce, family conflict, history of any type of abuse, etc.)

_____

_____

_____

_____

General Medical History

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

_____

_____

_____

_____

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

_____

_____

_____

_____

List any allergies or medication intolerances you have:

Neighborhood PSYCHIATRY

_____

_____

_____

_____

List any surgeries you have had in the past:

Surgery Hospital Date Reason

_____

_____

_____

_____

List any other hospitalizations you have had:

Reason Date

_____

_____

_____

_____

Do you smoke? ____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.)

_____

_____

_____

_____