Date: / /

New Patient Information

Name: _____ Sex: _____ Birthdate: _____ Age: _____

Presenting Problems: (Check all that apply)

	None	Mild	Moderate	Severe
Tired or Fatigued	☐	☐	☐	☐
Tension or Anxiety	☐	☐	☐	☐
Sleep Disturbance	☐	☐	☐	☐
Arguing with Significant Other	☐	☐	☐	☐
Feelings of Guilt	☐	☐	☐	☐
Concentration / Attention Problems	☐	☐	☐	☐
Abuse or Related Problems	☐	☐	☐	☐
Marital Problems	☐	☐	☐	☐
Problems with Children	☐	☐	☐	☐
Sexual Concerns	☐	☐	☐	☐
Alcohol or Drug Use Problems	☐	☐	☐	☐
Physical Complaints	☐	☐	☐	☐
Memory Problems / Irrational Fears	☐	☐	☐	☐
Work-related Problems	☐	☐	☐	☐
Eating Problems	☐	☐	☐	☐
Depression	☐	☐	☐	☐
Anger	☐	☐	☐	☐
Obsessions or Compulsions	☐	☐	☐	☐
Suicidal Thoughts	☐	☐	☐	☐
Other: _____	☐	☐	☐	☐

What would you like to accomplish in your counseling?

Name _____

Date of Birth _____

Pre-Treatment Medication Checklist

Please indicate all the medications you have ever been prescribed, include comments on effectiveness and reasons for discontinuing the medication.

ANTIDEPRESSANTS

- ☐ Anafranil (Clomipramine) _____
- ☐ Celexa (Citalopram) _____
- ☐ Cymbalta (Duloxetine) _____
- ☐ Desyrel (Trazodone) _____
- ☐ Effexor, (Venlafaxine) _____
- ☐ Elavil (Amitriptyline) _____
- ☐ ENSAM Transdermal Patch (Selegiline) _____
- ☐ Lexapro (Escitalopram) _____
- ☐ Luvox, (Fluvoxamine) _____
- ☐ Nardil (Phenelzine) _____
- ☐ Norpramin (Desipramine) _____
- ☐ Pamelor (Nortriptyline) _____
- ☐ Parnate (Tranylcypromine) _____
- ☐ Paxil, (Paroxetine) _____
- ☐ Pristiq (Desvenlafaxine) _____
- ☐ Prozac; Sarafem (Fluoxetine) _____
- ☐ Remeron, (Mirtazapine) _____
- ☐ Serzone (Nefazodone) _____
- ☐ Sinequan (Doxepin) _____
- ☐ Surmontil (Trimipramine) _____
- ☐ Tofranil (Imipramine) _____
- ☐ Vivactal (Protriptyline) _____
- ☐ Wellbutrin, (Bupropion)/Zyban _____
- ☐ Zoloft (Sertraline) _____

ANTI-ANXIETY and INSOMNIA MEDICATIONS

- ☐ Ambien, (Zolpidem) _____
- ☐ Ativan (Lorazepam) _____
- ☐ Benadryl (Diphenhydramine) _____
- ☐ BuSpar (Buspirone) _____
- ☐ Dalmane (Flurazepam) _____
- ☐ Halcion (Triazolam) _____
- ☐ Klonopin (Clonazepam) _____
- ☐ Librium (Chlordiazepoxide) _____
- ☐ Lunesta (Eszopiclone) _____
- ☐ Noctec (Chloral hydrate) _____
- ☐ ProSom (Estazolam) _____
- ☐ Restoril (Temazepam) _____
- ☐ Rozerem (Ramelteon) _____
- ☐ Serax (Oxazepam) _____
- ☐ Sonata (Zaleplon) _____
- ☐ Tranxene (Clorazepate) _____
- ☐ Unisom (Doxylamine) _____
- ☐ Valium (Diazepam) _____
- ☐ Vistaril, Atarax (Hydroxyzine) _____
- ☐ Xanax (Alprazolam) _____

OTHER MEDICATIONS NOT LISTED ABOVE

_____

STIMULANT MEDICATIONS

- ☐ Adderall _____
- ☐ Concerta, Daytrana TD Patch, Metadate, Ritalin (Methylphenidate) _____
- ☐ Dexedrine (Dextroamphetamine) _____
- ☐ Focalin (Dexmethylphenidate) _____
- ☐ Provigil _____
- ☐ Strattera (Atomoxetine) _____
- ☐ Tenex (Guanfacine) _____
- ☐ Vyvanse (Lisdexamfetamine) _____

MEDICATIONS FOR SIDE EFFECTS

- ☐ Artane (Trihexyphenadil) _____
- ☐ Benadryl (Diphenhydramine) _____
- ☐ Cogentin (Benztropine) _____
- ☐ Inderal (Propranolol) _____
- ☐ Parlodel (Bromocriptine) _____

MOOD STABILIZERS

- ☐ Carbatrol, Equetro, Tegretol (Carbamazepine) _____
- ☐ Depakote, (Valproic Acid) _____
- ☐ Eskalith, Lithobid (Lithium) _____
- ☐ Lamictal (Lamotrigine) _____
- ☐ Topamax (Topiramate) _____
- ☐ Trileptal (Oxcarbazepine) _____

ANTIPSYCHOTICS

- ☐ Abilify, (Aripiprazole) _____
- ☐ Clozaril, Fazaclo (Clozapine) _____
- ☐ Geodon, (Ziprasidone) _____
- ☐ Haldol (Haloperidol) _____
- ☐ Invega (Paliperidone) _____
- ☐ Loxitane (Loxapine) _____
- ☐ Mellaril (Thioridazine) _____
- ☐ Moban (Molindone) _____
- ☐ Navane (Thiothixene) _____
- ☐ Prolixin (Fluphenazine) _____
- ☐ Risperdal, (Risperidone) _____
- ☐ Serentil (Mesoridazine) _____
- ☐ Seroquel, (Quetiapine) _____
- ☐ Stelazine (Trifluoperazine) _____
- ☐ Thorazine (Chlorpromazine) _____
- ☐ Trilafon (Perphenazine) _____
- ☐ Zyprexa, (Olanzapine) _____

MEMORY

- ☐ Aricept (Donepezil) _____
- ☐ Exelon (Rivastigmine) _____
- ☐ Namenda (Memantine) _____
- ☐ Reminyl (Galantamine) _____

PSYCHOLOGY ASSOCIATES MID TOWNE

555 Mid Towne Street NE Suite 304 / Grand Rapids, Michigan 49503 / Phone 616.458.4444 / Fax 616.458.4440

___/___/___
(Date)

(Office Use Only)
Acct. #: _____
Provider: _____
DSM: _____

Identifying Information:

Client Name: _____
(Last) (First) (Middle)

Parent's Name (if client is child): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: H: _____ W: _____ Cell: _____

___ No calls to home
___ No calls to office
___ No mail to home

* Accounts must be kept current or statements will be mailed & calls will be made.

Sex: M or F Date of Birth: ___/___/___

Employer: _____ Responsible Party Soc. Sec. #: _____

Referred by: _____

Insurance Information:

Insurance Co.: _____ Policy Holder's Name: _____

Claim's Address & Phone #: _____

Policy Holder's SSN #: _____ Policy #: _____ Group #: _____

* Policy Holder's Date of Birth: ___/___/___

Patient's Relationship to Policy Holder:
(Check one)
____ Self
____ Spouse
____ Child

Policy Holder's Employer: _____

In Case of Emergency Contact: Name: _____ Phone: _____

Relationship: _____

► **Attached to this sheet is additional information needed and the terms and policies of our services to you.**

AUTHORIZATION:

I authorize any holder of medical information about me to be released to any insurance carrier for the purpose of reimbursement. I authorize benefit payment to go directly to my therapist.

Signed: _____ **Date:** _____

Revised 10.28.08

PSYCHOLOGY ASSOCIATES MID TOWNE

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POLICY INFORMATION

Thank you for choosing Psychology Associates Mid Towne for your mental health needs. We are committed to providing you with the highest quality, professional and ethical treatment. Please understand that payment of your bill is considered part of your treatment.

PAYMENT IS DUE AT TIME OF SERVICE. WE ACCEPT CASH, CHECKS, OR VISA / MASTERCARD.

The following is Psychology Associate's policy information, which we require you to ***read, initial, and sign*** prior to any treatment. If you do not understand, or if you have any questions, please ask.

Confidentiality _____

All information disclosed within sessions is confidential and may not be revealed to anyone without your expressed, written consent. There are exceptions to confidentiality, specifically IN CASES WHERE THE THERAPIST IS MANDATED BY LAW TO REPORT TO THE APPROPRIATE AUTHORITIES (i.e. WHERE THERE IS REASONABLE SUSPICION OF ABUSE OF CHILDREN, ELDERLY OR DISABLED PERSONS; WHERE THE CLIENT IS LIKELY TO HARM HIM/HERSELF OR OTHERS UNLESS PROTECTIVE MEASURES ARE TAKEN). If you have any questions about confidentiality, especially as it relates to children and adolescents, please ask your therapist. Please note that if you use insurance to help pay for your sessions, your signature on the bottom of our intake sheet grants us permission to provide your insurance carrier with information about you.

Insurance _____

We participate with several insurance companies. Participation means that we will accept what your insurance company approves. **You are responsible for any copays, deductibles or non-covered services at the time of service.** If we do not participate with your insurance company you are responsible for the full fee at the time of service. We will turn in a courtesy claim for you to your insurance so that they can reimburse you directly, apply the visit to your deductible, etc.

Payment for Services _____

Payment is expected at the time of the scheduled session unless you request other arrangements. If you are having difficulty paying your bill please talk with us regarding payment arrangements. If we receive payment other than expected from your insurance company, the remaining balance will be transferred to your account. Any outstanding balance must be paid in full within 30 days. We will mail a statement to all clients who have a balance due on their account. **If payment is not received within the calendar month, a $10 statement fee will be assessed.** If an account remains unpaid, we will pursue collection of this past due account.

Minor Patients _____

The adult accompanying a minor and/or the parents/guardians of the minor are responsible for full payment. For unaccompanied minors treatment will be denied unless charges have been pre-authorized to an approved credit card or payment is made by cash or check at time of service, unless prior arrangements have been made.

Building Policies _____

Psychology Associates Mid Towne, located in the Women's Health Center of West Michigan, has parking available in the attached Ellis parking structure. Please bring your parking ticket with you to your appointment and you will be given a parking voucher. You will need both the ticket and the voucher to exit the lot. Please note that this voucher will provide 1½ hours free parking for your time spent in our office. Without this voucher, you will be required to use credit card payment to exit the ramp.

There are fire alarm pull stations throughout the building. If a pull station is activated to create a false or nuisance alarm the fire department may assess a $1000 fine to the responsible party.

Women's Health Center of West Michigan is a smoke-free campus. This includes the building, the parking structure, and its surrounding property. Please dispose of your cigarettes, etc. before leaving your vehicle.

Cancellations / Missed Appointments _____

We request that appointment cancellations be made 48 hours in advance. Cancellations made less than 24 hours prior to the appointment will result in a $65 charge. Broken appointments without notice will be billed for the full fee.

Client Acknowledgement and Agreement:

* I have read and understood the above information.
* I have had the opportunity to ask questions and have any questions answered.
* I agree to pay the fee for each visit for services rendered.

_____ Date _____

Signature of patient or responsible party

Revised 10.21.16

Psychology Associates of Grand Rapids, P.C.
& Affiliated Therapists and Psychiatrists

PSYCHIATRIC ADDENDUM POLICY INFORMATION

The following is an addendum to Psychology Associate's policy information, which we require you to ***read*** and ***initial*** prior to any treatment.

Medication Refills _____
Medication refills will be addressed during scheduled appointments. A $20 charge will be applied for refills needed outside of scheduled appointment times.

Promptness _____
Please arrive on time for your appointment. If you arrive more than 10 minutes late for a med check appointment, the visit will have to be rescheduled. A late fee may be charged.

Cancellations / Missed Appointments _____
Scheduled appointments must be kept, or cancelled/rescheduled with at least 24 hour notice. Cancellations made less than 24 hours prior to the appointment will result in a **$65** charge. Broken appointments without notice will be billed the full fee of **$110**.

PSYCHOLOGY ASSOCIATES MID TOWNE

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Notice of Privacy Practices Acknowledgement of Receipt

I acknowledge that I have received the Psychology Associates of Grand Rapids, P.C. and Affiliated Therapists and Psychiatrists Notice of Privacy Practices.

_____

Print Patient Name

_____

Patient or Patient Representative Signature Date