River Oaks Psychiatry and Counseling

201 Towncenter Blvd

Tuscaloosa, AL 35406

205-650-0576

We are pleased that you have chosen River Oaks to provide your care. We have a few things to cover in advance of your first appointment at River Oaks to make sure your first visit goes as smoothly as possible.

We have enclosed a pre-registration packet and medical questionnaire for you to complete and bring with you to your first appointment. Please complete this prior to coming so there is no delay in you being seen. Please complete the entire packet and do not leave anything blank.

**Complete both front and back of all pages in the packet.**

1. Bring your prescription bottles with you to your first appointment.
2. If possible, bring a copy of your records from your previous place of treatment (the intake note, the psychiatrist’s last note from your last visit with them, and your labs from the last 3 months).
3. Please arrive at least 15-20 minutes prior to your appointment time to complete the rest of the new patient registration paperwork and insurance verification. You will not be able to attend your appointment until all registration is complete. Any insurance co-pays will be collected prior to your appointment as well.

Thanks again for choosing River Oaks.

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River Oaks

*Psychiatry and Counseling*

**Client Registration Form**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Male / Female

First Name Middle Name Last Name Date of Birth Gender-*Circle One*

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ House/Apt Number/Street City State Zip County

SSN: \_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_ Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary or Preferred Language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: (\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Highest education completed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Race: [ ] Black/African American [ ] White/Caucasian [ ] Alaskan Native [ ] American Indian [ ] Asian [ ] Native Hawaiian/or other Pacific Islander

 [ ] More than one race [ ] Other

Ethnic Origin: [ ] Not of Hispanic Origin [ ] Puerto Rican [ ] Cuban [ ] Other Hispanic [ ] Mexican/Mexican American [ ] Other

Employment Status: [ ] Full time [ ] Part time [ ] Unemployed/looking for work [ ] Homemaker [ ] Student [ ] Retired [ ] Disabled [ ] Unemployed/Not looking for work [ ] Not applicable (under age 16)

Choose one of the following: [ ] I live alone [ ]  I live with relatives/spouse [ ] I live with non-related persons [ ]  I live with a paid care provider

Number Living in Household: \_\_\_\_\_\_\_\_\_\_\_

Are you a Veteran? [ ] Yes [ ] No Choose one: [ ] not hearing impaired [ ] hearing impaired [ ] deaf

Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PCP Phone Number: (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referring Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] N/A

**Person Responsible for Payment**

[ ] Self or Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Client:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

 First Middle Last

**Primary Insurance Information**

Are you using any type of EAP (Employee Assistance Program) options? [ ] Yes [ ] No If *yes*, what company?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contract Number of Subscriber ID:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *If applicable*, Authorization Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber Name (if different from self):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber Date of Birth:\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_ Subscriber Social Security Number:\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_

Subscriber’s Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber’s Phone Number: (\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Secondary Insurance Information**

Are you using any type of EAP (Employee Assistance Program) options? [ ] Yes [ ] No If *yes*, what company?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contract Number of Subscriber ID:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *If applicable*, Authorization Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber Name (if different from self):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber Date of Birth:\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_ Subscriber Social Security Number:\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_

Subscriber’s Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber’s Phone Number: (\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

River Oaks

**GENERAL PRACTICE POLICIES**

**Appointment Policy**

A 24 hour notice is required to reschedule or cancel your appointment. All clients must arrive on time for their scheduled appointment. If you arrive late for your appointment you may or may not be seen depending on other scheduled appointments and the availability of your physician or therapist. If you are more than 15 minutes late you will not be seen and you may be subject to a “no-show” fee. If you are unable to cancel your appointment with the required 24 hour notice or you do not show to your appointment you may be charged a $50.00 “no-show” fee. Habitual offenders, more than 3 missed appointments or late cancellations, will be subject to dismissal from the clinic.

 Initials\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Payment for Services**

River Oaks will bill your insurance company directly following your appointment. Your co-payment and any deductibles and balances that may apply will be collected at the time you check in. Balances will not be carried over and are due at the time of service. If we are not billing an insurance company for your services, the full payment is due at the time of service. River Oaks accepts cash, debit, and most forms of credit cards. Failure to pay balances may result in a suspension or termination of services.

 Initials\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Confidentiality**

River Oaks follows all rules and regulations as stipulated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Please refer to your handout in this packet regarding HIPAA. The physicians and therapists of River Oaks function as a multi-disciplinary team to provide you the highest quality care and therefore may share information in your record regarding your care.

 Initials\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergencies and/or Medication Issues**

Office staff will take messages during normal business hours. Please allow up to 48 hours for a response as our providers have very busy schedules and are not in the office every day. If you are having an emergency after hours, you can call 911 or go to your local emergency room. No refills for medications will be called in after-hours, during holidays when the office is closed, or during the weekends.

 Initials\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Labs and Drug Screens**

It may be medically necessary for your physician or nurse practitioner to order lab or radiologic tests in order to provide the best treatment possible. It is your responsibility to obtain the ordered examinations. If you do not obtain these tests within a reasonable amount of time, your provider reserves the right to refuse to refill or prescribe medications until the required tests have been completed. Urine drug screens are also performed when necessary. All new patients and patients who are prescribed controlled medications will be required to complete an initial urine drug screen and will be subject to monthly urine rug screens thereafter. Any charges for urine drug screens or lab work or other tests are the responsibility of the patient if not covered by your insurance company.

 Initials\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dismissal**

If you are “dismissed” from River Oaks, this means you can no longer receive services, schedule appointments, get medications refills or consider our providers to be your physician/therapist. You will need to seek services/treatment from another provider or practice. Common Reasons for Dismissal: failure to keep appointments, frequent no-shows, noncompliance with your provider’s recommendations or instructions regarding important health concerns, abusive or vulgar language, behavior that is disruptive, verbal or physical aggression, failure to pay your bill.

 Initials\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent and Statement of Understanding**

I have read and understand these policies in their entirety and agree to abide by these terms. I am also aware that if I have questions about this document or any of the policies I am encouraged to discuss my questions with River Oaks staff.

Your signature below indicates your agreement to the terms of these policies. \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_

 Today’s Date

Patient (or parent/legal guardian) Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient (or parent/legal guardian) signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

River Oaks

Acknowledgement of Receipt

*(initial by each section)*

\_\_\_\_\_\_\_\_\_\_ I have read and understand and agree with the River Oaks General Practice Policies.

\_\_\_\_\_\_\_\_\_\_ I have been given a copy of the HIPAA Notice of Privacy Practices.

\_\_\_\_\_\_\_\_\_\_ I have read and understand and agree with the River Oaks Controlled Substances Contract.

\_\_\_\_\_\_\_\_\_\_ I understand that all fees and/or balances are to be paid at the time of service and that I am responsible for any charges not paid by my insurance. I understand that if I fail to pay my fees and/or balance, appropriate attempts will be made to collect these fees and that if all attempts are unsuccessful, my account may be turned over to a collection agency.

\_\_\_\_\_\_\_\_\_\_ I authorize River Oaks to release any information necessary in processing insurance claims for services rendered. I understand that if any agency or company, including insurance companies, are responsible for the payment or reimbursement of services, they have the right to review my medical records. I also authorize payment of benefits to River Oaks for these services.

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

Patient’s Printed Name

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

Patient’s Signature Date

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

Printed Name of Parent or Legal Guardian (if applicable)

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

Signature of Parent or Legal Guardian (if applicable) Date

**River Oaks Psychiatry and Counseling**

**Authorization for Disclosure of Health Information for Next of Kin/Emergency Contact**

**(release)**

I hereby authorize **River Oaks Psychiatry and Counseling** to disclose information about my care such as appointment times and any information necessary in the case of an emergency:

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_ River Oaks may speak to or leave voicemails for the individual(s) listed below regarding my treatment and/or

(initials) appointment scheduling.

Name Relationship to You Phone Number

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

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

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

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

I understand that this will include information related to (*initial where applicable*):

\_\_\_\_\_\_\_\_\_\_Psychiatric Care

 \_\_\_\_\_\_\_\_\_\_Treatment for alcohol and/or drug abuse

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire one year from date of signing.

I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164] , and the Privacy Act of 1974 [5 USC 552a].

The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

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

Signature of Patient (parent or legal guardian) Date

# NOTICE OF PRIVATE HEALTH INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW CLINICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

River Oaks Psychiatry and Counseling, in compliance with Federal regulations, will not use or disclose your health information without your consent or authorization, except as described in this notice or otherwise required by law.

**HOW WILL MY HEALTH INFORMATION BE USED?**

1. Your health information will be used for **TREATMENT**. Information will be recorded in your clinical record to diagnose your condition, determine a plan of treatment, and to provide care for you.
2. Your health information will be used for **PAYMENT** purposes. For example, we may send a bill to you or to a third-party payer/insurance company that will include information that identifies you and shows your diagnosis and treatment received.
3. Your health information will be used for **HEALTH CARE OPERATIONS**. Members of the staff will use information in your health record to assess the quality of care that you receive and determine how to continually improve the quality and effectiveness of the services we provide in a multi-disciplinary approach.
4. Your health information will be provided to other Health Care Providers at your request with a signed authorization. This is applicable to not just adults, but those as young as 14 years old and, by law, you are able to consent for your own health care, then your health care information will be kept private unless you sign an authorization form. Children under the age of 14 must have a parent or legal guardian sign the authorization form.
5. Your health information will be protected if you are receiving alcohol or drug abuse services from River Oaks. Any information that would identify you as a person seeking help for a substance abuse problem is protected under a separate set of federal regulations known as “Confidentiality of Alcohol and Drug Abuse Patient Records,”
6. 42 C.F.R. Part 2 (additional privacy protections beyond those that have already been described).

In those instances where you did authorize us to release your substance abuse related health information, the authorization will always be accompanied by a notice prohibiting the individual or agency / organization receiving your health information from re-releasing it unless permitted under the regulations 42 C.F.R., Confidentiality of Alcohol and Drug Abuse Patient Records.

1. Your health information will not be shared without your consent unless there is a court order to release your health information, the provision of your health information to medical personnel is needed in an emergency, or information is needed by qualified personnel for audits or program evaluations.
2. Your health information may be shared with others who participate in your care for certain diagnostic tests, second opinions, a copy service to make copies of clinical records, a transcription service to transcribe clinical information dictated by health care professionals, and the like. Other examples of disclosures include, but are not limited to the following:
	* Emergencies
	* Pursuant to a court order
	* To public health authorities
	* Disclosure to child protection agencies
	* To law enforcement officials in some circumstances
	* Disclosure to health oversight agencies

**YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION**

Although your health records are the physical property of River Oaks, you have the following rights concerning the information contained therein:

1. You have the right to request restrictions on our use of your protected health information. We do not however, have to agree to the restriction.
2. You may request communication to you outside the clinic, such as appointment reminders, bills, or explanations of health benefits be made in a confidential manner. We will accommodate reasonable requests.
3. You may inspect and copy your health information upon request. Again, this right is not absolute. In certain situations, such as if access would cause harm, we can deny access. If we deny you access, we will explain why and what your rights are, including how to seek review. If we grant access, we will tell you what, if anything, you have to do to get access. We reserve the right to charge a reasonable, cost-based fee for making copies.
4. If you believe your record contains an error, you may ask in writing that correct or new information be added. If there is a mistake, a note will be entered into your record to correct the error.
5. We do not have to grant the request if the following conditions exist:
	* We did not create the record;
	* The record is accurate and complete;
	* The records are not available to you as discussed immediately above.

If we deny your request for amendment / correction, we will notify you why, how you can attach a statement of disagreement to your records (which we may rebut), and how you can complain. If we grant the request, we will make the correction and distribute the correction to those who need it and those whom you identify to us that you want to receive the corrected information.

1. You may request an accounting of non-routine uses and disclosures, those other than for treatment, payment, and health care operations.
2. You may revoke your consent or authorization to use or disclose health information except to the extent that we have taken action in reliance on the consent or authorization.

|  |
| --- |
| **Patient Medical/Health Questionnaire** |
| **Patient name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_****Date Completed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Are you allergic to any medications?** | **yes** | **no** |   |
| **List any medications that you are allergic to. What reaction did you have to this medication?** |
| 1 |
| 2 |
| 3 |
| 4 |
| 5 |
|  |
| **Medications currently taking** | **Dosage/Frequency** | **Medical Reason for Taking** |
| 1 |  |  |
| 2 |  |  |
| 3 |  |  |
| 4 |  |  |
| 5 |  |  |
| 6 |  |  |
| 7 |  |  |
| 8 |  |  |
| 9 |  |  |
| 10 |  |  |
|  |  |  |
| **List all major medical problems or diagnoses** |
| 1 |
| 2 |
| 3 |
| 4 |
| 5 |
| 6 |
| 7 |
| 8 |
| 9 |
| 10 |
|  |
| **List past major surgeries Year** |
| 1 |
| 2 |
| 3 |
| 4 |
| 5 |
| **List any Psychiatric, Substance Abuse, or Major Medical Problems in FAMILY MEMBERS (biological).** |
| 1 |
| 2 |
| 3 |
| 4 |
| 5 |
| 6 |
| 7 |
| 8 |
| 9 |
| 10 |
| **Are you sexually active? Yes // No** |
| **Type of Birth Control Used (if appropriate):**  |
| **Do you drink alcohol? Yes // No If yes, about how much/how often?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  |
| **Do you use tobacco products? Yes // No If yes, what type and how often:** |
| **Caffeine Intake: Number of drinks; \_\_\_\_\_\_\_\_\_\_\_\_per day.**  |
| **Employed? Yes // No Retired? Yes // No**  |
| **Occupation**  |
| **Nature of work: Sedentary // Physical // Prolonged standing // Highly Stressful**  |
| **Duration of current profession : \_\_\_\_\_\_months \_\_\_\_\_\_years** |
| **\_\_\_Single \_\_\_Married \_\_\_Divorced \_\_\_Widowed \_\_\_Separated**  |
| **Number of children: \_\_\_\_\_boys \_\_\_\_\_girls** |
|  |
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|  |  |  |  |
| **Patient name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_** |
| **Current Symptoms/Problems/Review of Systems** |
|   | Yes | No  |   |
| **Constitutional**  |  |  |  |
|  ▫ Fever |  |  |  |
|  ▫ Malaise (fatigue) |   |   |   |
|  ▫ Recent weight changes |   |   | If yes, increased or decreased?  *(Circle one)* |
|  ▫ Changes in appetite  |   |   | If yes, has appetite increased or decreased?  |
| **Eyes** |  |  |  |
|  ▫ Blurred vision |  |  |  |
|  ▫ Double vision |   |   |   |
|  ▫ Visual changes |   |   |   |
| **Ears/Nose/Throat/Mouth**  |   |   |   |
|  ▫ Hearing loss  |   |   |   |
|  ▫ Tinnitus (ringing in ears) |   |   |   |
|  ▫ Nasal congestion |   |   |   |
|  ▫ Nasal discharge |   |   |   |
|  ▫ Sore throat  |   |   |   |
| **Respiratory** |   |   |   |
|  ▫ Cough |   |   |   |
|  ▫ Shortness of breath |   |   |   |
|  ▫ Chest tightness or pain |   |   |   |
|  ▫ Wheezing  |   |   |   |
| **Cardiovascular** |   |   |   |
|  ▫ Murmur |   |   |   |
|  ▫ Palpitations |   |   |   |
|  ▫ Edema |   |   |   |
| **Gastrointestinal**  |   |   |   |
|  ▫ Nausea/Vomiting |   |   |   |
|  ▫ Change in bowel habits  |   |   |   |
|  ▫ Diarrhea  |   |   |   |
|  ▫ Constipation |   |   |   |
|  ▫ Abdominal pain |   |   |   |
|  ▫ Blood in stools |   |   |   |
| **Genitourinary** |   |   |   |
|  ▫ Blood in Urine |   |   |   |
|  ▫ Painful urination |   |   |   |
|  ▫ Urinary urgency |   |   |   |
|  ▫ Burning |   |   |   |
|  ▫ Itching  |   |   |   |
| **Musculoskeletal**  |   |   |   |
|  ▫ Joint Pain |   |   |   |
|  ▫ Joint stiffness or swelling  |  |  |  |
|  ▫ Numbness or tingling sensation  |   |   |   |
| **Neurological**  |   |   |   |
|  ▫ Weakness |   |   |   |
|  ▫ Seizures or convulsions |   |   |   |
|  ▫ Migraine headaches  |   |   |   |
|  ▫ Numbness  |   |   |   |
|  ▫ Loss of balance  |   |   |   |
|  ▫ Paralysis |   |   |   |
|  ▫ Tremors |   |   |   |
| **Psychiatric** |   |   |   |
|  ▫ Difficulty concentrating  |   |   |   |
|  ▫ Insomnia  |   |   |   |
|  ▫ Changes in socializing  |   |   |   |
|  ▫ Substance abuse  |   |   |   |
|  ▫ Anxiety disorder  |   |   |   |
|  ▫ Irritability or mood changes  |   |   |   |
|  ▫ Suicidal thoughts or attempts  |   |   |   |
|  ▫ Anxiety  |   |   |   |
|  ▫ Depression  |   |   |   |
|  ▫ Forgetfulness |   |   |   |
|  ▫ Nervousness |   |   |   |
|  ▫ Quality of Sleep  |   |   |   |
|  ▫ Previous use of psychotropic medications? No // Yes | If yes, list any psychiatric medications previously used and why it was stopped. |
|    | 1 |
| 2 |
| 3 |
| 4 |
| 5 |

River Oaks Psychiatry and Counseling

Children Only (Ages 17 and under)

Supplemental Questionnaire

Child’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_

School he/she attends: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Grade Level: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Special Education Services/IEP?: [ ] Yes [ ] No

1. Any complications during the pregnancy, labor, or delivery of this child? [ ] Yes [ ] No

If yes, explain here:

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

2. Did he/she reach developmental milestones on time? [ ] Yes [ ] No

First age he/she started walking: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First age he/she started talking in simple sentences: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age child potty-trained: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Does he/she socialize well with other children? [ ] Yes [ ] No

4. Any trouble learning to read and/or write? [ ] Yes [ ] No [ ] Not Applicable

5. Has he/she repeated any grades? [ ] Yes [ ] No

6. Briefly describe any academic problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

7. Any conflicts with teachers? [ ] Yes [ ] No

If yes, briefly describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8. Are the current grades C average or above? [ ] Yes [ ] No

9. Any siblings? [ ] Yes [ ] No

If yes, list ages and gender? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

10. Does he/she get along with the siblings? [ ] Yes [ ] No

11. Are both biological parents living? Mother [ ] Yes [ ] No Father [ ] Yes [ ] No

12. Are parents married, separated, divorced, never married, living together? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

13. How does he/she get along with parents?

Mother\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Father \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

14. Good relationship with step parent(s)? [ ] Yes [ ] No [ ] Not Applicable

15. Is this child adopted? [ ] Yes [ ] No

16. Is the primary caregiver someone other than a biological parent? [ ] Yes [ ] No Who?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

17. List the people (first name only) that live in the home and their relation to the child.