Brandon Psychiatric Group

New Patient Registration

DATE

1 PATIENT DEMOGRAPHICS

Name ≫	FIRST	M.	LAST	Gender ≫	❑ MALE ❑ FEMALE
Previous Names ≫					
DOB ≫	MM/DD /	YYYY	SSN ≫	555-55-5555	
Phone ≫	CELL		HOME		
Preferred Contact ≫	❑ CELL ❑ HOME	E-mail ≫	EMAIL		
Address ≫	STREET				
≫	CITY		STATE	ZIP	
Consent ≫	I can be **contacted** at the phone number, email address, or mailing address listed above regarding healthcare information, appointments, and/or billing. I am aware that **messages** may be left at the number or sent to the email address listed above that contain confidential healthcare information. I understand that I am responsible for **updating** this information (in writing) when it may change.				INITIAL
Ethnicity/ Race ≫	❑ AMERICAN INDIAN OR ALASKA NATIVE ❑ HISPANIC OR LATINO ❑ ASIAN ❑ DECLINE ❑ BLACK/AFRICAN AMERICAN ❑ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER ❑ WHITE				

2 EMERGENCY CONTACT

REQUIRED	Name ≫	FIRST	M.	LAST	
Relationship ≫		Phone ≫	CELL		
Address ≫	STREET				
≫	CITY		STATE	ZIP	

3 EMPLOYMENT INFO

Status ≫	❑ EMPLOYED [OCCUPATION: _____ EMPLOYER: _____]
≫	❑ UNEMPLOYED ❑ RETIRED ❑ STUDENT ❑ DISABLED [START DATE:] ❑ PENDING DISABILITY

4 CONSENT FOR TREATMENT

Read ≫	By signing below, I hereby authorize the providers of this facility to provide treatment according to my medical diagnosis and/or mental health.				
Print ≫		Sign ≫		Date ≫	

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5 INSURANCE INFORMATION

Insurance card/s presented today is/are up to date. If my coverage changes, I will provide a copy of my new insurance card/s to the office prior to receiving treatment.	Initial ≫	

Primary Insurance ≫	❑ I DO NOT HAVE PRIMARY INSURANCE.		
	COMPANY	MEMBER ID	
≫	GROUP ID	POLICY HOLDER	RELATIONSHIP
≫	POLICY HOLDER DOB	POLICY HOLDER SSN	
Secondary Insurance ≫	❑ I DO NOT HAVE SECONDARY INSURANCE.		
	COMPANY	MEMBER ID	
≫	GROUP ID	POLICY HOLDER	RELATIONSHIP
≫	POLICY HOLDER DOB	POLICY HOLDER SSN	

Prescription Drug Plan ≫	❑ SAME AS PRIMARY INSURANCE	❑ SAME AS SECONDARY INSURANCE	
	COMPANY	MEMBER ID	
≫	RX BIN	RX PCN	RX GROUP

6 BILLING POLICIES

Payment is to be collected at the time of service.	INITIAL
Checks are no longer accepted in office. Please prepared to provide cash or card for payment.	INITIAL
Bounced checked sent to the billing office directly will be subject to a returned check fee of $35.00.	INITIAL
Cancellations made with less than 24 hours notice are subject to a fee of $25.00 made prior to rescheduling. Checks will not be accepted for this fee.	INITIAL
Same day appointments are not guaranteed and will be subject to an administrative fee of $50.00 in addition to regular copayments and fees.	INITIAL

7 AUTHORIZATION OF BENEFITS

Read ≫	The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. If my insurance is billed, I will be responsible for any portion of my bill not covered by my insurance company. I understand that I am financially responsible for any balance. I also authorize Dr. Hany Botros-Mikhail or my insurance company to release any information required to process my claims. I am aware that it is **my responsibility to update my insurance with the office** when it changes.

Print ≫		Sign ≫		Date ≫	

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8 ALLERGIC REACTIONS

❑ NO KNOWN DRUG ALLERGIES		Severity ⩥			Reaction ⩥
		MILD	MOD.	SEVERE	
Allergy 1 ⩥	MED	❑	❑	❑	
Allergy 2 ⩥	MED	❑	❑	❑	
Allergy 3 ⩥	MED	❑	❑	❑	
Allergy 4 ⩥	MED	❑	❑	❑	
Food Allergies ⩥					
Environmental Allergies ⩥					

9 CURRENT MEDICATIONS

Prescription Medications ⩥	❑ I AM NOT CURRENTLY TAKING PRESCRIPTION MEDICATIONS	
Medication 1 ⩥	NAME	DOSAGE
Medication 2 ⩥	NAME	DOSAGE
Medication 3 ⩥	NAME	DOSAGE
Medication 4 ⩥	NAME	DOSAGE
Over the Counter Medications ⩥	❑ I AM NOT CURRENTLY TAKING OVER THE COUNTER MEDICATIONS	
⩥	LIST	

10 PHARMACY

REQUIRED	Name ⩥		Phone ⩥	
Location ⩥				

All prescriptions will be electronically sent to this pharmacy during scheduled office visits only. Only one pharmacy may be used at any given time. However, non-controlled prescriptions can be transferred from one pharmacy to another. Be sure to update the office with your pharmacy information when this may change. Please allow until the end of the business day for your prescriptions to be sent to your pharmacy. Lost/stolen/damaged medications will NOT be replaced.

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1 THE REASON/S FOR TODAY'S VISIT

Symptoms ≫	
≫	
≫	

2 ONGOING HEALTH ISSUES

SELECT ALL THAT APPLY ≫	Do you have any of the following problems?				
❑	GLAUCOMA	❑	THRYOID DISEASE: Underactive	❑	ANEMIA
❑	ASTHMA	❑	THRYOID DISEASE: Overactive	❑	BACK PAIN (CHRONIC)
❑	CANCER, type: _____	❑	LUPUS	❑	FAINTING
❑	ABNORMAL HEARTH RHYTHM	❑	DEMENTIA	❑	HEARING LOSS
❑	GOUT	❑	FIBROMYALGIA	❑	HIGH BLOOD PRESSURE
❑	HEPATITIS	❑	SEXUALLY TRANSMITTED DISEASE	❑	LOW BLOOD PRESSURE
❑	KIDNEY DISEASE	❑	TRAUMATIC BRAIN INJURY	❑	MULTIPLE SCLEROSIS
❑	KIDNEY STONES	❑	HEART DISEASE	❑	HIGH CHOLESTEROL
❑	MIGRAINE HEADACHES	❑	EPILEPSY / SEIZURE DISORDER	❑	STROKE / TIA
❑	ARTHRITIS	❑	SLEEP APNEA	❑	DIGESTIVE PROBLEMS
❑	BPH (enlarged prostate)	❑	DIABETES TYPE 1	❑	LOW TESTOSTERONE
❑	ENCEPHALITIS / MENINGITIS	❑	DIABETES TYPE 2	❑	IRRITABLE BOWEL SYNDROME
❑	LIVER DISEASE	❑	OBESITY	❑	COPD / EMPHYSEMA
❑	HIV /AIDS	❑	OTHER:		

FOR WOMEN ONLY ≫	Date of last menstrual period:	MM/DD/YYYY		
Are you currently pregnant or think you might be pregnant?	❑ YES ❑ NO	Are you currently breastfeeding?	❑ YES ❑ NO	
Birth Control Method	LIST			

3 PAST MEDICAL HISTORY

Major Events ≫	LIST
Past Surgeries ≫	LIST
Family Health History ≫	LIST

4 PAST PSYCHIATRIC HISTORY

Past Psychiatric Hospitalizations ⩥	❑ No prior psychiatric hospitalizations.		
REASON	**DATES**	**LOCATION**	**TREATMENT**

Prior Mental Health Treatment ⩥	❑ No prior mental health treatment.		
FACILITY / DOCTOR	**DATE STARTED**	**DATE ENDED**	**REASON DISCONTINUED**

Prior Attempts of Suicide ⩥	❑ Yes ❑ No	IF YES, METHOD/S:
Substance Abuse History ⩥	❑ Yes ❑ No	IF YES, SPECIFY:

5 CURRENT PROVIDERS

Primary Care	Office Name ⩥		Doctor ⩥	
Phone ⩥		Location ⩥		
Counseling	Office Name ⩥		Therapist ⩥	
Phone ⩥		Location ⩥		
Pain Management	Office Name ⩥		Doctor ⩥	
Phone ⩥		Location ⩥		

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6 SOCIAL HISTORY

Smoking Status ≫	❑ NON-SMOKER ❑ EX-SMOKER ❑ CHEWS TOBACCO ❑ CIGAR SMOKER ❑ PIPE SMOKER CIGARETTE SMOKER: ❑ LIGHT (1-9/day) ❑ MODERATE (10-19/day) ❑ HEAVY (20-39/day) ❑ VERY HEAVY (40+/day)	
Alcohol Use ≫	1. How often do you have a drink containing alcohol? ❑ NEVER ❑ MONTHLY OR LESS ❑ 2-4 TIMES A MONTH ❑ 2-3 TIMES A WEEK ❑ 4+ TIMES A WEEK	
	2. How many standard drinks containing alcohol do you have on a typical day? ❑ 1 OR 2 ❑ 3 OR 4 ❑ 5 OR 6 ❑ 7 TO 9 ❑ 10 OR MORE	
	3. How often do you have 6 or more drinks on 1 occasion? ❑ NEVER ❑ LESS THAN MONTHLY ❑ MONTHLY OR LESS ❑ WEEKLY ❑ DAILY OR ALMOST DAILY	
Financial Resources ≫	1. Describe your difficulty paying for the very basics like food, housing, medical care: ❑ VERY HARD ❑ HARD ❑ SOMEWHAT HARD ❑ NOT VERY HARD ❑ DECLINE	
Education ≫	Highest Education Level Completed:	LIST
Physical Activity ≫	1. How many days of moderate to strenuous exercise, like a brisk walk, did you do in the last 7 days?	DAYS
	2. On those days that you engage in moderate to strenuous exercise, how may minutes, on average, do you exercise?	MINS
Stress ≫	1. Do you feel stress – tense, restless, nervous, or anxious, or unable to sleep at night because you mind is trouble all the time – these days? ❑ NOT AT ALL ❑ ONLY A LITTLE ❑ TO SOME EXTENT ❑ RATHER MUCH ❑ VERY MUCH ❑ DECLINE	
Social Isolation & Connection ≫	❑ MARRIED ❑ WIDOWED ❑ DIVORCED ❑ SEPARATED ❑ NEVER MARRIED ❑ LIVING W/ PARTNER	
	1. In a typical week, how many times do you talk on the telephone with family, friends, or neighbors?	# TIMES
	2. In a typical week, how often do you get together with friends or relatives?	# TIMES
	3. In a typical year, how often do you attend church or religious services?	# TIMES
	4. Do you belong to any clubs or organizations such as church groups unions, fraternal or athletic groups, or school groups?	❑ YES ❑ NO
Exposure to Violence ≫	1. Within the last year, have you been humiliated or emotionally abused in other ways by your partner or ex-partner?	❑ YES ❑ NO
	2. Within the last year, have you been afraid of your partner or ex-partner?	❑ YES ❑ NO
	3. Within the last year, have you been raped or forced to have any kind of sexual activity by your partner or ex-partner?	❑ YES ❑ NO
	4. Within the last year, have you been kicked, hit, slapped, or otherwise physically hurt by your partner, or ex-partner?	❑ YES ❑ NO
Gender Identity ≫	❑ MALE ❑ FEMALE ❑ TRANSGENDER MALE /TRANS MAN / FEMALE-TO-MALE ❑ TRANSGENDER FEMALE / TRANS WOMAN / MALE-TO-FEMALE ❑ GENDERQUEER ❑ ADDITIONAL CATEGORY (please specify): _____ ❑ DECLINE	
Sexual Orientation ≫	❑ STRAIGHT OR HETEROSEXUAL ❑ LESBIAN, GAY, OR HOMOSEXUAL ❑ BISEXUAL ❑ OTHER (please specify): _____ ❑ DECLINE	

7 PAST PSYCHIATRIC MEDICATIONS

DIRECTIONS: PLEASE COMPLETE SECTION TO THE BEST OF YOUR RECOLLECTION.
This will help in getting insurance coverage for medications that are not covered and require **prior authorization**.

Anti-Depressants »	HELPFUL **(H)**	NOT HELPFUL **(N)**	CURRENT USE **(C)**	HISTORY OF USE **(Hx)**	ADVERSE REACTION **(R)**	DATE RANGE	COMMENTS
Prozac (fluoxetine)	❑	❑	❑	❑	❑		
Zoloft (sertraline)	❑	❑	❑	❑	❑		
Luvox (fluvoxamine)	❑	❑	❑	❑	❑		
Paxil (paroxetine)	❑	❑	❑	❑	❑		
Celexa (citalopram)	❑	❑	❑	❑	❑		
Lexapro (escitalopram)	❑	❑	❑	❑	❑		
Effexor (venlafaxine)	❑	❑	❑	❑	❑		
Cymbalta (duloxetine)	❑	❑	❑	❑	❑		
Wellbutrin (buproprion)	❑	❑	❑	❑	❑		
Remeron (mirtazepine)	❑	❑	❑	❑	❑		
Sinequan (doxepin)	❑	❑	❑	❑	❑		
Trintellix (vortioxetine)	❑	❑	❑	❑	❑		
Viibryd (vilazodone HCL)	❑	❑	❑	❑	❑		
OTHER:	❑	❑	❑	❑	❑		
Mood Stabilizers »	**H**	**N**	**C**	**Hx**	**R**	DATE RANGE	COMMENTS
Tegretol (carbamazepine)	❑	❑	❑	❑	❑		
Lithium	❑	❑	❑	❑	❑		
Neurontin (gabapentin)	❑	❑	❑	❑	❑		
Depakote (valproate)	❑	❑	❑	❑	❑		
Trileptal (oxcarbazepine)	❑	❑	❑	❑	❑		
Lamictal (lamotrigine)	❑	❑	❑	❑	❑		
Topamax (topiramate)	❑	❑	❑	❑	❑		
OTHER:	❑	❑	❑	❑	❑		

8 PAST PSYCHIATRIC MEDICATIONS (CONTINUED)

Anti-Psychotics ⋗	H	N	C	Hx	R	DATE RANGE	COMMENTS
Seroquel (quetiapine)	❑	❑	❑	❑	❑		
Zyprexa (onlanzepine)	❑	❑	❑	❑	❑		
Geodon (ziprasidone)	❑	❑	❑	❑	❑		
Abilify(aripiprazole)	❑	❑	❑	❑	❑		
Clozaril (clozapine)	❑	❑	❑	❑	❑		
Haldol (haloperidol)	❑	❑	❑	❑	❑		
Proxlixin (fluphenazine)	❑	❑	❑	❑	❑		
Risperdal (risperidone)	❑	❑	❑	❑	❑		
Latuda (lurasidone)	❑	❑	❑	❑	❑		
OTHER:	❑	❑	❑	❑	❑		
Sedative/Hypnotics ⋗	**H**	**N**	**C**	**Hx**	**R**	DATE RANGE	COMMENTS
Ambien (zolpidem)	❑	❑	❑	❑	❑		
Sonata (zaleplon)	❑	❑	❑	❑	❑		
Rozeram (ramelteon)	❑	❑	❑	❑	❑		
Restoril (temazepam)	❑	❑	❑	❑	❑		
Desyrel (trazodone)	❑	❑	❑	❑	❑		
Lunesta (eszopiclone)	❑	❑	❑	❑	❑		
OTHER:	❑	❑	❑	❑	❑		
Stimulants ⋗	**H**	**N**	**C**	**Hx**	**R**	DATE RANGE	COMMENTS
Adderall (amphetamine)	❑	❑	❑	❑	❑		
Concerta (methylphenidate)	❑	❑	❑	❑	❑		
Ritalin (methylphenidate)	❑	❑	❑	❑	❑		
Strattera (atomoxetine)	❑	❑	❑	❑	❑		
Vyvanse (lisdexamfetamine)	❑	❑	❑	❑	❑		
OTHER:	❑	❑	❑	❑	❑		
Anti-Anxiety Medications ⋗	**H**	**N**	**C**	**Hx**	**R**	DATE RANGE	COMMENTS
Vistaril (hydroxyzine)	❑	❑	❑	❑	❑		
Busar (buspirone)	❑	❑	❑	❑	❑		
Xanax (alprazolam)	❑	❑	❑	❑	❑		
Ativan (lorazepam)	❑	❑	❑	❑	❑		
Klonopin (clonazepam)	❑	❑	❑	❑	❑		
Valium (diazepam)	❑	❑	❑	❑	❑		
OTHER:	❑	❑	❑	❑	❑		

9 OFFICE POLICIES

PLEASE REVIEW THE FOLLOWING POLICIES CAREFULLY	INITIAL
A "No Show" is missing a scheduled appointment; A "Late Cancellation" is cancelling an appointment without calling to cancel 24 hours in advanced of a scheduled office visit. Please be aware that as a courtesy we try to call two business days before to remind you of the appointment. However, it is ultimately the patient's responsibility to remember their own appointments. No-shows and late-cancellations delay the delivery of health care to other patients. In the case of a medical emergency, please stop in the office to complete a request for this fee to be waived; written documentation of the medical emergency will be required. **A charge of $25.00 will be assessed for each no show or late cancellation prior to rescheduling another appointment.**	
Medication refills and medication changes will be issued only through a scheduled office visit. Refills are unable to be authorized for missed or cancelled appointments. Early refills will not be authorized. Lost/stolen/damaged medications and prescriptions will not be replaced.	
Updating demographic and insurance information is the patient's responsibility.	
Payment is to be collected at the time of service. Checks are no longer accepted.	
Tests and procedures done in office and referrals for additional services may utilize a third-party service. The patient is financially responsible for these services.	
Being aware of medication insurance coverage is the patient's responsibility. **We recommend asking for a copy of the formulary medications from your insurance company prior to your visit.**	
Due to the nature of the practice, we kindly ask that you refrain from bringing children to these appointments for their safety and well-being. You will be asked to reschedule and may be charged a fee.	
Smoking is no longer permitted on site.	
Aggressive or abusive behavior towards staff and/or other patients will not be tolerated. If a disruption occurs in the office, you may be asked to leave or be dismissed from practice.	
PATIENT AGREEMENT	INITIAL
I am responsible for my medications. I will not share, sell, or trade my mediations. I will not take anyone else's medications. **I will bring my bottles with me to each appointment.**	
I will not increase my medication until I speak with my doctor or nurse at an office visit.	
I will keep all scheduled follow up appointments that are recommended by my doctor or nurse.	
I agree to give a saliva/urine/blood sample, if asked, to test for illicit drug use and compliance in order to remain on controlled substance treatment. This sample MUST be provided at the time of service.	
If I am pregnant/nursing or become pregnant while taking any medication, I will immediately notify my provider.	
I will only use one prescriber for controlled substances**. I will notify my provider of any new controlled prescriptions issued to me.**	
I will not contact or attempt to reach any office staff or providers, including Dr. Hany Botros-Mikhail, outside of the regular office contact information which is located on our website.	

By signing this below, I am acknowledging that I am aware of the office policies stated above. I understand that any violation of these policies could result in discharge from practice and care.

Print ≫		Sign ≫		Date ≫	

20 NOTICE OF PRIVACY PRACTICES

HIPAA ≫	This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**
Your Rights ≫	**Get a copy of your paper or electronic medical record**. *Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.*
≫	**Correct your paper or electronic medical record.** *We may say "no" to your request, but we'll tell you why in writing within 60 days.*
≫	**Request confidential communication.** *You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.*
≫	**Ask us to limit the information we share.** *You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it affects your care.*
≫	**Get a list of those with whom we've shared your information.** *We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.*
≫	**Get a copy of this privacy notice.** *You can ask for a paper copy of this notice at any time.*
≫	**Choose someone to act for you.** *If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.*
≫	**File a complaint if you believe your privacy rights have been violated.** *We will not retaliate against you for filing a complaint.*
Your Choices ≫	You have some choices in the way that we use and share information as we: **tell family and friends about your condition or provide mental health care.**
Our Uses and Disclosures ≫	**We may use and share your information as we:**
≫	**Treat you.** *We can use your health information and share it with other professionals who are treating you.*
≫	**Run our organization.** *We can use and share your health information to run our practice, improve your care, and contact you when necessary*.
≫	**Bill for your services** *We can use and share your health information to bill and get payment from health plans or other entities.*
≫	**Help with public health and safety issues.** *This includes preventing disease, helping with product recalls, reporting adverse reactions to medications, and reporting suspected abuse, neglect, or domestic violence.*
≫	**Comply with the law.** *We will share information about you if state or federal laws require it.*
≫	**Work with a medical examiner or funeral director**
≫	**Address workers' compensation, law enforcement, and other government requests**
≫	**Respond to lawsuits and legal actions**
Our Responsibilities ≫	Law requires us to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
Changes to the Terms ≫	We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.
Acknowledgement ≫	**By signing below, I am attesting that I have been provided a copy of HIPAA Privacy Policy.**

Print ≫		Sign ≫		Date ≫	