Maureen Briggs, Ph.D.

Child, Adolescent, and Adult Psychotherapy

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New Patient Registration

Welcome. We look forward to helping you reach your treatment goals. Please take a few minutes to complete this form. The questions are designed to help us best meet your treatment needs. If the person seeking care is a child, the parent or guardian should complete this form. If you have any questions, your treating clinician will be happy to answer them. Please note that this questionnaire will become part of your medical record.

Today's Date: _____

Patient Name: _____ Date of birth: _____ ☐ Female ☐ Male

Mailing Address: _____ City: _____ Zip: _____

Street Address: _____ City: _____ Zip: _____
(if different from above)

Patient SSN: _____ Employer/Occupation: _____

☐ Single ☐ Married ☐ Sep. ☐ Divorced ☐ Widow Full time Student? ☐ Yes ☐ No E-mail: _____

Home phone:(_____)_____ Work phone: (_____)_____ Cellular: (_____) _____
OK to contact there? ☐ Yes ☐ No OK to contact there? ☐ Yes ☐ No OK to contact there? ☐ Yes ☐ No

Primary Care Dr.: _____ Doctor's phone #: _____

Emergency contact: _____(_____)_____
Name Relationship to patient Phone number

Please list other people living in your household and their relationship to you _____

_____

_____

Primary Insurance Information:

Insured Name: _____

Insured SSN: _____

Insured DOB: _____

Employer: _____

Health Plan: _____

Patient's Relationship to the Insured:
☐ Self ☐ Spouse ☐ Dependent

Member #: _____

Policy / Group#: _____

Health Plan phone #: _____

Secondary Insurance Information:

Insured Name: _____

Insured SSN: _____

Insured DOB: _____

Employer: _____

Health Plan: _____

Patient's relationship to the Insured:
☐ Self ☐ Spouse ☐ Dependent

Member #: _____

Policy / Group#: _____

Health Plan phone #: _____

Mental Health Plan(s) (Please consult plan benefit summary.): _____

(Turn to page 2)

Version 1 - 20041118

Please describe your reason(s) for seeking treatment at this time. Approximately when did these problems begin? If there is a particular event which triggered your decision to seek treatment now, please list the event:

_____

_____

_____

_____

Please rate the severity of any of the following issues or problems you would like to work on in treatment. You may choose more than one, and you may leave blank any which are not present.

1=NONE 2=MILD 3=MODERATE 4=SEVERE 5=EXTREME

____ Depression	____ Lack of friends	____ Marriage/Relationship issues
____ Anxiety	____ Loneliness	____ Sexuality / sexual issues
____ Stress	____ Loss of someone close to you	____ Eating disorder
____ Mood swings	____ School problems	____ Medication problems
____ Behavior problems	____ Work problems	____ Feeling out of touch with reality
____ Difficulty concentrating	____ Family problems	____ Abuse / victimization issues

____ Other _____

Please indicate how much the issue(s) for which you are seeking treatment are affecting the following areas of your life:

	No Effect	Mild Effect	Moderate Effect	Severe Effect	Extreme Effect	Not Applicable
Marriage/Relationship	☐	☐	☐	☐	☐	☐
Family	☐	☐	☐	☐	☐	☐
Job/School Performance	☐	☐	☐	☐	☐	☐
Friendships	☐	☐	☐	☐	☐	☐
Financial situation	☐	☐	☐	☐	☐	☐
Physical health	☐	☐	☐	☐	☐	☐
Anxiety level/Nerves	☐	☐	☐	☐	☐	☐
Mood	☐	☐	☐	☐	☐	☐
Eating habits	☐	☐	☐	☐	☐	☐
Sleeping habits	☐	☐	☐	☐	☐	☐
Sexual functioning	☐	☐	☐	☐	☐	☐
Ability to concentrate	☐	☐	☐	☐	☐	☐
Ability to control temper	☐	☐	☐	☐	☐	☐
Spirituality	☐	☐	☐	☐	☐	☐
Substance abuse	☐	☐	☐	☐	☐	☐

What result(s) do you expect from treatment? _____

_____

_____

Have you ever received outpatient or inpatient mental health or substance abuse treatment before? If so, please list dates, treating clinician's name, facility, and the issue for which treatment was sought: If more room is needed, check here ☐ and attach another sheet.

_____

_____

_____ **(Turn to page 3)**

Please list any medications you're currently taking: (name, dosage, frequency; include "over the counter" drugs)

_____

_____

_____

Do you have any allergies to food/medications? ☐ Yes ☐ No If yes, please describe: _____

_____

_____

Check any of the following which have affected you:

	Current	Past	Year		Current	Past	Year
Dizziness	☐	☐	_____	High blood pressure	☐	☐	_____
Loss of consciousness	☐	☐	_____	Diabetes	☐	☐	_____
Seizures, convulsions	☐	☐	_____	Overweight	☐	☐	_____
Severe/recurrent headaches	☐	☐	_____	Underweight	☐	☐	_____
Weakness, paralysis	☐	☐	_____	Nausea, vomiting	☐	☐	_____
Memory, concentration prob.	☐	☐	_____	Diarrhea	☐	☐	_____
Speech problem	☐	☐	_____	Constipation	☐	☐	_____
Vision problem	☐	☐	_____	Ulcer	☐	☐	_____
Hearing problem	☐	☐	_____	Other intestinal problems	☐	☐	_____
Thyroid problem	☐	☐	_____	Loss of bowel control	☐	☐	_____
Asthma	☐	☐	_____	Loss of urinary control	☐	☐	_____
Shortness of breath	☐	☐	_____	Other urinary problem	☐	☐	_____
Chest pain	☐	☐	_____	Men: prostate problem	☐	☐	_____
Palpitations/irreg. heartbeat	☐	☐	_____	testicular problem	☐	☐	_____
Unusual fatigue	☐	☐	_____	Women: menstrual problem	☐	☐	_____
Severe infectious illness	☐	☐	_____	breast disease	☐	☐	_____

Have you had any medical hospitalizations or surgery? ☐ Yes ☐ No If yes, please list year, reason, doctor, facility.

_____

_____

Most recent physical examination: Doctor: _____ Date: _____

Significant findings? _____

Lifestyle issues: Please describe level of use of the following:

Caffeine: _____

Tobacco: _____

Alcohol: _____

Other drugs: _____

Have you ever thought you should decrease or stop your use of any of the above? ☐ Yes ☐ No

Has anyone else ever suggested you should decrease or stop your use of any of the above? ☐ Yes ☐ No

Please list any **family members** (parents, grandparents, aunts, uncles, cousins, siblings, children) who have had **mental health problems**, and describe. _____

_____

_____ **(Turn to page 4)**

CONFIDENTIALITY:
All information between provider and patient is held strictly confidential unless:

1. the patient authorizes release of information with his/her (or guardian's) signature.
2. the patient presents a physical danger to self.
3. the patient presents a danger to others.
4. child/elder abuse/neglect are suspected.

In the latter two cases, we are required by law to inform potential victims and legal authorities so protective measures can be taken.

FINANCIAL POLICY:
Fees will be discussed with you. Your copayment, coinsurance, and deductible payments are due at the time of service, unless other arrangements have been made with this office. For services rendered to minor children, the parent requesting the services is responsible for payment of same, and this office will not involve itself in legal disputes regarding payment. Accounts older than 60 days may incur interest at a rate of 1% monthly (12% annual rate). Accounts older than 90 days may be referred to an outside agency for collection.

CONSENT FOR TREATMENT
I further authorize and request that any clinician within the Office of Maureen Briggs, Ph.D. to whom I am referred carry out reasonable examinations, treatments, and/or diagnostic procedures which now or during the course of my care as a patient are advisable. I understand that the purpose of these procedures will be explained to me upon my request and that I may refuse treatment except in the situations which represent a danger to myself or others. I also understand that while this course of therapy is designed to be helpful, it may at times be difficult and uncomfortable.

CANCELLED / MISSED APPOINTMENTS / PHONE CONSULTS / REPORTS / INSURANCE ACCOUNTING FEES
A scheduled appointment means that time is reserved only for you. You will be billed directly for appointments missed or canceled with **less than 48 hours notice,** according to the scheduled fee. _____ *(Initials)*

OUT OF PLAN PATIENT ADDENDUM
Extended phone consultations, treatment instructions, and written reports handled by Dr. Briggs directly will be billed at the hourly rate. These services **when done outside of session visits**, are not covered by insurance. _____ *(Initials)*
The extraordinary time spent obtaining insurance authorizations, contesting denials, and submitting statements has resulted in the need to bill patients a **"separate monthly $20 accounting fee".** This is not covered by insurance. _____ *(Initials)*

RELEASE OF INFORMATION TO HEALTH PLAN ADMINISTRATORS
I authorize the release of information regarding my care to my health plan for the payment of claims, certification/case management decisions and other purposes related to the administration of benefits for my Health Plan.

AUTHORIZATION OF MEDICAL PAYMENTS DIRECTLY TO MAUREEN BRIGGS, Ph.D.
I authorize the payment of medical benefits to Maureen Briggs, Ph.D. for all treatment and services.

RELEASE OF INFORMATION TO COORDINATING PRACTITIONERS
I authorize the exchange and release of information to my Primary Care Physician and other Treating Professionals as indicated below:

Name of Professional - *Printed*	Phone Number	Name of Professional - *Printed*	Phone Number
Name of Professional - *Printed*	Phone Number	Name of Professional - *Printed*	Phone Number

I understand and agree to all of the above information.

Patient Name - *Printed*	Guardian Name, if applicable - *Printed*	Date
Patient Name - *Signature*	Guardian Name, if applicable - *Signature*	Date