

Paul Michael Remis, M.D.

Child, Adolescent, and Adult Psychiatry
Consultation and Medication Management

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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.

Patient Name: _____ Date of birth: _____ **Today's Date:** _____
 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 #: _____

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

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 #: _____

(Turn to page 2)

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
<input type="checkbox"/> Depression		<input type="checkbox"/> Lack of friends		<input type="checkbox"/> Marriage/Relationship issues
<input type="checkbox"/> Anxiety		<input type="checkbox"/> Loneliness		<input type="checkbox"/> Sexuality / sexual issues
<input type="checkbox"/> Stress		<input type="checkbox"/> Loss of someone close to you		<input type="checkbox"/> Eating disorder
<input type="checkbox"/> Mood swings		<input type="checkbox"/> School problems		<input type="checkbox"/> Medication problems
<input type="checkbox"/> Behavior problems		<input type="checkbox"/> Work problems		<input type="checkbox"/> Feeling out of touch with reality
<input type="checkbox"/> Difficulty concentrating		<input type="checkbox"/> Family problems		<input type="checkbox"/> Abuse / victimization issues
<input type="checkbox"/> 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Job/School Performance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Friendships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Financial situation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety level/Nerves	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating habits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleeping habits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual functioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to concentrate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to control temper	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spirituality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Substance abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

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 Paul Michael Remis, M.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. Remis 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 PAUL M. REMIS, M.D.

I authorize the payment of medical benefits to Paul M. Remis, M.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

DUPLICATION PROHIBITED WITHOUT WRITTEN PERMISSION FROM PAUL MICHAEL REMIS, M.D.

Version 3 - 20040622