PSYCHIATRIC ASSOCIATES OF WEST MICHIGAN, PLC

PLEASE PRINT Date: __________

Patient Name: ____ Sex: M F

First Mid Int. Last

Date of Birth: ____________________ Social Security: ____________________________

Street Address: ____

City: _____________________________ State: _____________ Zip: __________________

Daytime Phone: _________________________ Evening Phone: ________________________

Email ______________________________Statement Preference: EBill _______Mail _______

Patient's Employer: ____

City/State Where Located: ____________________________

Primary Care Physician: ____

Address or Phone: ____

Current Therapist: _____________________________________ Phone: ______________

Who referred you to our office?: ____

In the event that we need to contact you or return your call, may we leave a message?

On an answering machine? Yes ______ No______

With another person at above #'s? Yes _____ No ______

FOR MINOR CHILDREN OR PATIENTS WITH GUARDIANS:

(In divorce situation please list person patient resides with first)

Parent/Guardian #1: ______________________________________ Relationship: ________

Parent #1 Date of Birth: ____________________ Parent SS# ___________________________

Address: ____

Contact #1: _________________________ Contact #2: ____________________________

PLEASE BRING P/W TO APPOINTMENT, DO NOT MAIL TO THE OFFICE

Parent/Guardian #2: ____ Relationship: ________

Parent #2 Date of Birth: _____________________ Parent SS# ___________________________

Address: ____

Contact #1: __________________________ Contact #2: ______________________________

PRIMARY INSURANCE COMPANY: ____

Name of Policy Holder: ____________________________________ Sex: M F

Relationship to Patient: _______________ DOB: _____________ Soc. #: ___________________

Contract/Member ID: ____________________________ Group: _________________________

SECONDARY INSURANCE COMPANY: ____

Name of Policy Holder: ____________________________________ Sex: M F

Relationship to Patient: _______________ DOB: _____________ Soc. #: ___________________

Contract/Member ID: ____________________________ Group: _________________________

ALL COPAYS AND DEDUCTIBLES ARE DUE AT TIME OF SERVICE.

INSURANCE RELEASE:

I authorize the release of any information my physician may feel is necessary to process my insurance claims. This may include information about my mental health. I authorize participating insurance payments directly to my provider. I fully understand that I will be responsible for any amounts due following a response from my insurance, including deductible and non-covered services. I understand that if I have an insurance that Psychiatric Associates does not participate with that I am responsible for payment in full at the time of service and I will be provided with a claim form to turn into my insurance company for any reimbursement.

____ Date: _______________________

Signature of Patient/Parent/Guardian

PSYCHIATRIC ASSOCIATES OF WEST MICHIGAN, PLC
FINANCIAL POLICY

Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require that you sign prior to any treatment.

IF WE DO NOT PARTICIPATE WITH YOUR INSURANCE COMPANY
PAYMENT IN FULL IS DUE AT THE TIME OF SERVICE
WE ACCCEPT CASH, CHECKS, AND VISA/MASTERCARD/DISCOVER

Regarding Insurance:

We participate with several insurance companies which may or may not be yours. 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. Failure to pay will result in a fee of $10 to mail you a statement.

Usual and Customary:

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's determination of usual and customary rates.

Minor Patients:

The parent/guardian that accompanies the minor is responsible for full payment at the time of service regardless of what any divorce settlement might say. If a parent is not attending the appointment, payment needs to be sent with the patient or a credit card may be put on file to cover the co-pay/co-insurance.

Collection Costs:

You are in default if you fail to comply with the terms of this agreement, including failing to make a required payment when due. If you default we will turn your account over to our collection agency and we may choose to also charge you for any reasonable collection costs that are incurred by us. This will also result in termination from the practice.

Appointment Cancellation:

If you must cancel an appointment, you must do so at least **24 hours in advance** in order to avoid a charge up to the full cost of the appointment. Late cancellations and no shows are not billable to insurance companies and are your responsibility. For your convenience, we have 24hour voice mail. If you miss more than one appointment, you may be required to pay the balance prior to rescheduling.

Prescription Refills:

In the event that a prescription refill is necessary prior to your regularly scheduled appointment, please **allow 48 hours' notice.** There will be a charge of $10.00 for refills of controlled substances. This charge is your responsibility and is not covered or reimbursed by your insurance company.

I have read the above financial policy and understand that I am financially responsible for all charges for services that I receive, including the balance remaining after payment of possible insurance benefits.

____ ___________________________

Signature of Patient or Guardian **Date**

MEDICAL HISTORY

NAME:_____________________________________DATE OF BIRTH:________________DATE:_________________

List all current medications:

Are you allergic to any medications? If so, please list:

Surgical History:

Please circle any of the below conditions that you are currently being treated for:

Diabetes	High Blood Pressure	Heart Disease
Lung Disease	Cancer	Kidney Disease
Liver Disease	Epilepsy/Seizures	Strokes

Please check the symptoms you have experienced in the last two weeks:

YES	NO	CONSTITUTIONAL	YES	NO	ENDOCRINE
		Decreased Appetite			Heat or Cold Intolerance
		Tiredness/Fatigue			PMS
		Fever			Hair Loss
		CARDIOVASCUALR			PULMONARY
		Increased Heart Rate			Shortness of Breath
		Chest Pain			Cough
		Irregular Pulse			Wheezing
		DERMATOLOGIC			MUSCULOSKETAL
		Rash or Itching			Back/Joint Pain
		Psoriasis			Weakness
		HEENT			NEUROLOGIC
		Dry Mouth			Headaches
		Decreased Hearing			Tremors/Tics
		Difficulty Swallowing			Dizziness/Fainting
		Blurry Vision			Numbness/Tingling
		GASTROINTESTINAL			GU
		Increased Appetite			High Libido
		Nausea/Vomiting			Low Libido
		Constipation			Difficulty Urinating
		Diarrhea			Incontinence/Urgency
		Abdominal Pail			Erectile Problems
		HEMATOLOGIC			Painful Urination
		Swollen Glands			ALLERGIES
		Easily Bruise			Hay Fever

PRIMARY CARE PHYSICIAN

PSYCHIATRIC ASSOCIATES OF WEST MICHIGAN, PLC

CONSENT TO RELEASE CONFIDENTIAL INFORMATION

Between: ___________________________ And: Psychiatric Associates of West Michigan, P.L.C

_____________________________ 1403 60th Street SE Kentwood, MI 49508

_____________________________ 616-719-4488 phone 616-719-4480 fax

Patient: _____________________________

DOB: ______________________________

SS# ______________________________

I, ______________________________(patient) give my permission to the above named to obtain__ and/or release __ by means of verbal, written, photocopy, or fax, certain confidential information about my psychiatric and/or medical treatment. This information may contain and/or treatment for HIV, infection and/or AIDS virus, and treatment recommendations under the provisions of P.A. 258 of 1974 as amended, Section 748, Subsection 5.

Information and/or Material to be released:

__X__Medical Treatment Record ____Psychotherapy Notes

_____Phone Notes ____Entire Record (excludes therapy notes)

_____Other: Physician/Hospital records

Purpose of Disclosure:

____Continuation of care/discharge planning _____Personal Use __Other:______

__X_Coordination of Treatment Services _____Transfer of Care

I am also aware of all consequences that might occur as a result of signing this consent form or of my refusal to do so. My signature means that I have read this form and/or have had it read to me and explained in a language I can understand. All the blank spaces have been filled in except in signatures and dates.

Right to revoke or terminate-As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager. This can be done in person or by mailing a request to Psychiatric Associates of West Michigan, P.L.C. at the above address.

Expirations or termination of authorization-This authorization will expire at the end of the calendar year in which the authorization was initiated, unless you specify an earlier termination. You must submit a new authorization after the expiration date to continue the authorization. You have the right to terminate this authorization at any time. You must notify our privacy manager, in writing, if you decide to terminate the authorization prior to the normal expiration date. (Please list and earlier expiration if less than one year:___________________)

Redisclosure-We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of Psychiatric Associates of West Michigan P.L.C.

Non-conditioning Statement-If the patient does not consent to this release, his/her treatment will not be compromised in any way.

A true and exact photo static/faxed copy of this authorization shall have the same effect as the original.

____

(Patient Signature or “X”) (Date Signed) (Witness)

____

(Patient’s Guardian) (Date Signed) (Witness)

THERAPIST

PSYCHIATRIC ASSOCIATES OF WEST MICHIGAN, PLC

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(Patient Signature or "X") (Date Signed) (Witness)

(Patient's Guardian) (Date Signed) (Witness)

CONSENT FOR TREATMENT

I, _______________________________, have been informed by PAWM

that I am in need of psychiatric treatment. It has been recommended that I receive psychotherapy and/or conjoint psychotherapy and/or chemotherapy, and/or group psychotherapy for the treatment of my illness. I understand that I may not be compelled to take the prescribed medication and that I may decide to stop taking it at any time. If laboratory work is required I authorize my doctor to release my diagnosis to the lab for insurance purposes. I also understand that I have the right to terminate my treatment with my doctor at any time I choose to do so, in writing. I also understand that it is my responsibility to inform the doctor of any changes in my physical condition. I further understand that although my doctor believes that this treatment will be of benefit to me, there is no guarantee as to the results that may be expected. On this basis I authorize my doctor to render the necessary psychiatric services as he/she deems advisable.

Signature:____________________________
Date:________________________________

Witness initials: _______________

Date:________________________