



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 ACCEPT 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.**

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Signature of Patient or Guardian

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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
		CARDIOVASCULAR			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 Pain			Erectile Problems
		HEMATOLOGIC			Painful Urination
		Swollen Glands			ALLERGIES
		Easily Bruise			Hay Fever

SYMPTOM REVIEW

PLEASE CHECK ALL SYMPTOMS THAT DESCRIBE YOU OVER THE LAST FEW WEEKS:

DOWN MOOD  NOT INTERESTED IN ACTIVITIES

FEEL IRRITATED OR ANGRY  LESS INTERESTED IN SEX

FEEL WORTHLESS  DECREASED APPETITE

INCREASED APPETITE  CAN'T CONCENTRATE

FEEL TIRED  FEEL HOPELESS

CRYING SPELLS  SUICIDAL THOUGHTS

UNABLE TO HAVE FUN  GUILTY FEELINGS

FAST HEARTBEAT  FEELINGS EASILY HURT

FREQUENT SWEATING  DON'T LIKE BEING ALONE

DIZZINESS  NIGHTMARES

DIARRHEA  OVERLY AMBITIOUS

STOMACH TROUBLE  IMPULSIVE

CHEST PAIN  FEEL LIKE HURTING SOMETHING

MUSCLES TWITCHING OR JUMPING  FEEL LIKE SMASHING THINGS

NAUSEA OR VOMITING  NOT LISTENING TO PEOPLE

HEADACHES  CAN'T SIT STILL

PANIC ATTACKS  HOP FROM TASK TO TASK

EASILY DISTRACTED

HOW LONG DOES IT TAKE YOU TO FALL ASLEEP? \_\_\_\_\_(MINUTES)

HOW MANY TIMES DO YOU WAKE UP PER NIGHT?\_\_FOR HOW LONG? \_\_ (MIN)

HOW MUCH WEIGHT HAVE YOU GAINED/LOST (CIRCLE ONE) RECENTLY ? \_\_\_\_\_

HOW MANY DRINKS OF ALCOHOL DO YOU AVERAGE PER WEEK ? \_\_\_\_\_

WHAT OTHER RECREATIONAL DRUGS DO YOU USE? \_\_\_\_\_

WHAT OTHER RECREATIONAL DRUGS HAVE YOU EVER USED? \_\_\_\_\_

HAVE YOU EVER MADE ANY SUICIDE ATTEMPTS? \_\_\_\_\_

**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 60<sup>th</sup> 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:

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: \_\_\_\_\_  
 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

CONSENT TO RELEASE CONFIDENTIAL INFORMATION

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

\_\_\_\_\_ 1403 60<sup>th</sup> Street SE Kentwood, MI 49508

\_\_\_\_\_ 616-719-4488 phone 616-719-4480 fax

Patient: \_\_\_\_\_

DOB: \_\_\_\_\_

SS# \_\_\_\_\_

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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: \_\_\_\_\_