Southwest General Medical Group, Inc.
Behavioral Health

Dear New Patient:

Welcome to our practice. Enclosed are forms for you to fill out in advance of your appointment to assist our office staff in making sure that we have the correct information necessary to bill your insurance and provide you with quality care.

Please fill out all the forms completely. The day of your appointment please bring your completed forms, drivers license or another form of a picture ID and your insurance card and your copay. We collect copays at each visit. If you do not have insurance you will be expected to pay at the time of service. We accept check, cash or credit card.

We will call you prior to your appointment to remind you of your appointment. If you need to cancel or reschedule we need a 48 hour notice.

Once again, welcome to our practice. We look forward to providing you with quality care.

Cordially,
Southwest General Group, Inc.
Behavioral Health

7265 Old Oak Boulevard / Middleburg Heights, Ohio / 44130 / Phone: 440.816.5790 / Fax: 440.816.5806

Amendments to Your PHI. You have the right to request changes or corrections to the PHI we maintain about you. We are not obligated to make all requested changes but will give each request careful consideration. All requests must be in writing (signed and dated) and sent to Medical Records. The request must state the reasons for the change requested. If a change you request is made by us, we may also notify others who have copies of the uncorrected record if we believe that such notification is necessary. An amendment request form may be obtained by contacting Medical Records.

Accounting of Disclosures. You have the right to request an accounting of certain disclosures of your PHI, which would not include disclosures made for treatment, payment, or health care operations, or when an authorization form was obtained. The first accounting in any 12-month period is free; you may be charged a reasonable cost-based fee for each subsequent accounting you request within the same 12-month period. Requests must be in writing (signed and dated) and sent to Medical Records. A form may be obtained from the Privacy Officer.

Restrictions on Use and Sharing of Your PHI. You have the right to request us to restrict how we use and disclose your PHI. We are not required to agree to your restriction request but will attempt to accommodate reasonable requests, when appropriate. You have the right to terminate any agreed-to restriction at any time. You also have the right to restrict disclosures of your PHI to your health plan with respect to health care for which you have paid out of pocket in full.

Breach Notification. You have the right to receive notification of breaches of your unsecured PHI.

Complaints. If you believe your privacy rights have been violated, you can file a complaint with the Privacy Officer. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services. in writing within 180 days of discovering a violaion of your rights. There will be no retaliation against you for filing a complaint.

Acknowledgment of Receipt of Notice. You will be asked to sign an acknowledgment form that you received this Notice of Privacy Practices.

If you have questions or need further assistance regarding this Notice, you may contact the Privacy Officer at 440-816-4719, 18697 Bagley Road/C-07, Middleburg Hts., Ohio 44130.

This Notice of Privacy Practices is effective August 1, 2013
Form #163584 05/19

NOTICE OF PRIVACY PRACTICES

SOUTHWEST COMMUNITY HEALTH SYSTEM

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.

Southwest Community Health System complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, gender identity or gender expression.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-440-816-5050.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-440-816-5050.

This Notice of Privacy Practices describes how Southwest Community Health System, Southwest General Health Center, Southwest Community Pharmacy, and Southwest General Medical Group, Inc. (collectively referred to as "Southwest"), including its volunteers and other members of its workforce, physicians and other health care professionals caring for you at Southwest may use and share your Protected Health Information ("PHI"). PHI is information in any form (paper, verbal, electronic, or recording (audio, video, etc.)) that identifies you and that describes your physical or mental health condition and your health care services (past, present and future). Your health information is protected by law for up to 50 years after death. This Notice of Privacy Practices applies to members of the Southwest Medical Staff when they provide care for you at Southwest General Health Center, but does not apply to their private medical practices. Southwest and its Medical Staff are cooperating in the protection of your health information and privacy rights, but such cooperation should not be construed to mean that the Health Center and members of its Medical Staff are the agents or representatives of the other, or in any way are responsible for each other's actions or failure to act.

We are required by law to maintain the privacy of our patients' PHI and to provide you with this Notice of Privacy Practices ("Notice") of our legal duties and privacy practices. We are required to follow the terms of this Notice, so long as it remains in effect. We reserve the right to change the terms of this Notice as necessary and any new Notice will be effective for all PHI maintained by Southwest. You have a right to receive a copy of the currently effective Notice at any registration area or information desk in a Southwest facility or medical office, by downloading a copy from our website at *www.swgeneral.com,* or by contacting the Southwest Privacy Officer at 440-816-4719.

I. HOW SOUTHWEST MAY USE AND DISCLOSE YOUR PHI

Authorization. The ways in which we may use or share your PHI without separate authorization are listed below. We are prohibited from selling your PHI without your authorization, as well as other uses and disclosures for which the Privacy Rule requires your authorization (i.e., marketing purposes and disclosure of psychotherapy notes, where appropriate). We will not use your PHI for any *other* purpose unless you have signed a form authorizing such use or disclosure. When state or federal law requires a special consent or authorization, we will make all reasonable efforts to obtain such consent or authorization. At any time, you have the right to revoke an authorization to disclose your information if you do so in writing, however, such revocation will not apply to any action we have taken based on your original authorization.

Uses and Disclosures that Do Not Require Your Authorization

For Treatment. We may use and share your PHI as necessary to provide, coordinate or manage your health care treatment. We may also share your PHI with another health care provider who is not associated with us but who provides medical treatment to you. For example, doctors and nurses involved in your care may use your medical information to plan a course of treatment for you. This information may also be shared with other health care providers, for instance, if you are an inpatient at Southwest and you are to receive home health care after being discharged, we may disclose your PHI to that home health care agency so that a plan of care can be prepared for you. We may disclose mental health PHI (with the exception of psychotherapy notes) as permitted under HIPAA and state law, to other health care providers for purposes of continuity of care.

For Payment. We may use and share your PHI as necessary to receive payent for the health care services provided to you. For instance, we may forward information regarding treatment you received to your insurance company to obtain payment for the services provided to you, unless you have paid out of pocket in full for your health care and have requested that

we restrict disclosure of your PHI to your health plan with respect to such information.

For Health Care Operations. We may use and share your PHI as necessary for our health care operations which include clinical improvement, business management, accreditation and licensing and defending ourselves in any legal action. For instance, your care may be reviewed at one of our quality review committees where we regularly review care rendered to patients. Under certain circumstances and as permitted by law, we may also share your PHI with another health care provider or health plan for their health care operations.

Health Information Exchange. To help enhance the quality of your care, Southwest participates in Health Information Exchanges (HIE). Your healthcare providers can use this secure electronic network to share your health records for a better picture of your health needs. You may opt-out of having your PHI shared through the HIE any time either during registration or by submitting a written request to Medical Records. Opting out of HIE sharing means your providers will need to obtain your records, as permitted or required by law and as described in this Notice, by other means (e.g., fax, mail, secure email).

Patient Directory. If you are receiving emergency services or are an inpatient here, or if you are at the Health Center for some lengthy outpatient procedures, we may direct people to your room or give your room telephone number to anyone who calls or visits the Health Center and asks for you by name. In some circumstances, we may also give a general statement about your medical condition (for instance "fair" or "critical"). Your religious affiliation may also be provided to members of the clergy. You have the right during registration to request that we not disclose any of this information as part of our Patient Directory.

Family or Others Involved. Unless you object, we may from time to time disclose your PHI to family, friends, and others whom you have designated, who are with you at Southwest, or after your death. We would only disclose to those who are involved and only relevant PHI to assist in their involvement in caring for you or paying for your care. If you are unable or unavailable to agree or object, or are facing an emergency medical situation or in the case of a public disaster, we may share limited PHI with your family and friends or to an organization that is involved in disaster relief efforts if we believe such a disclosure is in your best interest.

Business Associates. Certain aspects of our services may at times be performed through arrangements with outside persons or organizations, such as auditing services or billing services; and at times, outside persons or organizations may assist us in our care for you. At times, it may be necessary for us to provide your PHI to these outside persons or

organizations that assist
obligated to protect yo
obtain written assurance
your PHI.

Fundraising. From tim
to raise money as part o
the right to opt out of re
to do this will be descrit

Confidential Commun
communicate with you
you wish appointment r
wish for mail to be sen
will honor reasonable r
should make such req
medical professional du
an appointment.

Research. In limited c
PHI for research purpos
wish to compare outco
drug and will need to re
either your specific au
will be protected by stri
Institutional Review I
Southwest or by applica

To Public Health
Agencies. We may dis
any purpose required by
injuries, births and deat
may also disclose you
oversight agency conc
activities.

Abuse, Neglect, and L
if such information cau
are required or permitt
also disclose your PHI
victim of abuse, neglec
to law enforcement offi
wounds, injuries, and
order (or warrant) for a
are seeking your identif

organizations that assist us. In all cases, these business associates are obligated to protect your PHI in the same manner we are and we obtain written assurances from them stating their agreement to protect your PHI.

Fundraising. From time to time we may use your PHI to contact you to raise money as part of our charitable fundraising efforts. You have the right to opt out of receiving fundraising communications and how to do this will be described in the communications you receive.

Confidential Communication. You have the right to request we communicate with you by particular means or locations, such as if you wish appointment reminders not to be left on voice mail or if you wish for mail to be sent to a different address than your home. We will honor reasonable requests for confidential communication. You should make such requests by informing the Southwest General medical professional during your next visit or when calling to make an appointment.

Research. In limited circumstances, we may use and disclose your PHI for research purposes. For example, a research organization may wish to compare outcomes of all patients who received a particular drug and will need to review a series of medical records. In all cases, either your specific authorization will be obtained or your privacy will be protected by strict confidentiality requirements applied by the Institutional Review Board that reviews research conducted at Southwest or by applicable law.

To Public Health Authorities and Government Oversight Agencies. We may disclose your PHI to public health authorities for any purpose required by law such as reporting of certain diseases and injuries, births and deaths, and for required health investigations. We may also disclose your PHI if required by law to a government oversight agency conducting audits, licensure review, or similar activities.

Abuse, Neglect, and Law Enforcement. We may disclose your PHI if such information causes us to suspect abuse or neglect which we are required or permitted by law to report to authorities. We may also disclose your PHI as required by law if we believe you are a victim of abuse, neglect or violence. We may also disclose your PHI to law enforcement officials as required or permitted by law to report wounds, injuries, and suspicion of certain crimes, or with a court order (or warrant) for a serious crime and law enforcement officials are seeking your identification and location.

Food and Drug Administration. We may disclose your PHI to the Food and Drug Administration or its designee, if necessary, to report such things as adverse reactions, product defects, or to participate in product recalls.

Disclosures to Employers. We may disclose your PHI to your employer when we have provided services to you at the request of your employer to determine workplace-related illness or injury. We may also disclose your PHI to workers' compensation agencies, if necessary, for your workers' compensation benefit determination.

Judicial and Administrative Activities. We may disclose your PHI if required to do so by court order or validly issued subpoena or for any other official judicial or governmental administrative action.

Funeral Directors / Coroners / Organ Donation Agencies. We may disclose your PHI to coroners and/or funeral directors consistent with law and we may also disclose your PHI, if necessary, to arrange an organ or tissue donation from you or a transplant for you.

For Public Health Reasons or the Safety of Others. We may disclose your PHI in limited instances if we suspect a serious threat to someone else's or the public's health or safety, such as to notify persons that they have been exposed to a communicable disease or are in danger, or in cases of investigating outbreaks of disease. We may provide immunization records to schools when required for public health reasons.

Military / National Security. We may disclose your PHI as required by armed forces services if you are a member of the military; we may also disclose your PHI if required by law for national security or intelligence activities.

Required By Law. We may use and/or disclose your PHI if we are otherwise required by law to disclose the information.

II. RIGHTS YOU HAVE REGARDING YOUR PHI

Access to Your PHI. You have the right to inspect and request copies of your PHI that we maintain or to direct us to send a copy to a third party. You may request paper or electronic copies. We may charge you a reasonable cost-based fee for such copies and any postage. Request for records must be in writing and sent to Medical Records. An Authorization form may be downloaded at www.swgeneral.com. under Patients & Visitors. If you are denied access to your records, you have the right to an explanation as to the legal basis for the denial and to object to such denial by contacting the Privacy Officer. You may also access a portion of your electronic medical record any time using the Southwest General HealtheLife patient portal. Go to www.swgeneral.com for more details on setting up an account or ask about HealtheLife at the registration desk.

Southwest General Medical Group, Inc.

Patient Registration Form

Patient Acct #M: _____

PATIENT

Patient's Name: Last	**First *(legal)*:**	**Middle Initial:**	
Address:			
City:	State:	Zip:	
Sex: ☐ Male ☐ Female	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed		
SSN#:	Birthdate:	Age:	
Home Phone #:	Cellular #:	Work #:	Ext:
Employer:			
Email Address:			
Can a message be left at your home? ☐ Yes ☐ No	Left on your answering machine? ☐ Yes ☐ No		

Race ☐ White ☐ Asian ☐ Black/African American ☐ Native Hawaiian ☐ Alaskan Native-American Indian ☐ More than one race ☐ Unreported/Refused	**Ethnicity** ☐ Hispanic ☐ Non Hispanic ☐ Unreported / Refused **Preferred Language :**	**Student:** ☐ Full Time ☐ Part Time ☐ Not Attending **How would you like to get notification of preventative reminders** ☐ US Mail ☐ Phone

Preferred Local Pharmacy:

Preferred Mail Order Pharmacy:

Emergency Contact:

Relationship to Patient: Home Phone: ( ) Cell Phone: ( )

**** Please present your insurance card to the receptionist so that a copy can be made for our records****

INSURANCE

Primary Insurance: _____ ID# _____ Group # _____

Subscriber's Name: _____ DOB _____ SSN _____

Relation to Patient ☐ Self ☐ Spouse ☐ Father ☐ Mother ☐ Guardian ☐ Other

Employer Name: _____

Secondary Insurance _____ ID # _____ Group # _____

Subscriber's Name: _____ DOB: _____ SSN: _____

Relation to Patient ☐ Self ☐ Spouse ☐ Father ☐ Mother ☐ Guardian ☐ Other

FINANCE

Insured / Responsible Party (who is responsible for payment)

Name Last: First (legal) Middle Initial:

Address (if different than patient)

City:	State:	Zip:
SSN#:	Birth date:	
Phone #:	Relation to patient: ☐ Self ☐ Spouse ☐ Father ☐ Mother ☐ Guardian ☐ Other	

Authorization for Treatment and Financial Disclosure

I authorize *SGMG, INC physicians* to release any information that may be necessary to comply with subpoenas, governmental regulations and laws. I also authorized this physician to release the following parties, any information they request from the physician: Medicare and/or insurer. For physician services provided to me, I assign to the physician all insurance or other payments made by other for my physician services. I request that payment of authorized benefits be made either to me or on my behalf to the above provider for services furnished by that physician. I authorize release to the indicated insurance carrier any medical information about me needed too determine these payments for related services.

I understand that I am responsible for payment of all bills for any services provided by an *SGMG physician*. If I do not provide the name of an insurance company or other party obligated to pay my bills, I will provide the physician with personal credit information and cooperate with physicians in establishing plan for payment of my physician services.

_____ _____

Patient or Responsible Party Signature Date

OUTPATIENT PSYCHOSOCIAL HISTORY
SOUTHWEST GENERAL MEDICAL GROUP
BEHAVIORAL HEALTH

Patient/Family Education Record

Patient Name: _____ Date: _____
Date of Birth: _____

To help us better meet your needs regarding teaching and education through out practice, please check any of the boxes below that may affect your/the patient's ability to learn.

YES	NO	
☐	☐	Hearing Impairment Describe: _____
☐	☐	Vision Impairment Describe: _____
☐	☐	Speaking Impairment Describe: _____
☐	☐	Language Barriers Describe: _____
☐	☐	Cultural or Religious Practices Describe: _____
☐	☐	Emotional/Psychological Barriers Describe: _____
☐	☐	Financial Concerns Describe: _____
☐	☐	Desire and Motivation to Learn Describe: _____
☐	☐	Physical Limitations Describe: _____
☐	☐	Do you feel safe in your current environment and relationship? Describe: _____
☐	☐	Nutritional Concerns: Sudden weight gain or loss in the past six months? Describe: _____
☐	☐	Pain Management: Any pain in last six months? Location of pain? Duration of pain? On a scale of 1 - 10 with 10 the worst, what intensity is your pain? Describe: _____

I prefer to learn: ☐ Visually ☐ Auditory ☐ By Demonstration

Reviewed By: _____ Date: _____

I have received a copy of the Patient's Rights, Responsibilities, and Office Policies. I have been able to ask questions regarding any of my concerns. I understand my rights, responsibilities, and the policies involved in my treatment with any of the SGMG, Inc. Behavioral Health Providers.

Andrew McGill, CNP, Alison Henton, CNP, Jeffrey Riskin, LISW-S, Alexandra Beard, MD., Chris Salzer, LISW-S, Daniel Polster, MD, and/or David Fox, MD.

_____ _____

Patient or legal guardian's signature **Date**

SOUTHWEST GENERAL MEDICAL GROUP, INC.
BEHAVIORAL HEALTH

Office Policies and Patient Responsibilities

Follow-up Appointments:

Appointments rescheduled with less than 24 hours notice will result in a $25.00 fee.

Appointments that are not kept and not rescheduled (no-show) will result in a $25.00 fee.

Insurance companies do not cover the no-show fee and therefore the insurance company will not be billed. This no show fee will be your responsibility. Failure to pay may result in patient's termination from the practice per proper protocol.

If you miss or cancel, three appointments in a row the provider will no longer follow you as a patient. You will be discharged from the practice.

Family appointments (two or more consecutive appointments for siblings) are permitted.

Family appointments that are frequently rescheduled and or not kept will preclude the scheduling of future family appointments.

Medications:

Please bring all currently prescribed medications to each appointment, or be aware of how much is left, and how many refills are left. Refills and changes to medications should occur in the context of an office appointment.

Calls may be placed to the office outside of an appointment to request a prescription of medications that are not suitable for refills (Concerta, AdderallXR).

We are available 24hours a day for emergencies: Call 440-816-5790

INTAKE FORM

SOUTHWEST GENERAL MEDICAL GROUP, INC. BEHAVIORAL HEALTH

Name: _____ **Date:** _____ **Date of Birth:** _____

What is the main reason you are seeking services? _____

_____

How were you referred? _____

Name of Medical Provider: _____

Name of prior psychiatrists or psychiatric nurse practitioners: _____

Name of previous psychotherapist: _____

Dates of previous treatment: _____

Psychiatric History:

Have you been diagnosed with any psychiatric disorder(s) previously? If so, please specify: _____

_____

Have you ever been hospitalized for any psychiatric reason: **Yes or No** (circle one)

Reason & Dates: _____

Name of hospital: _____

Do you have a history of any of the following?

Attempted suicide? **Yes or No** (circle one). If so, dates: _____ Method: _____

Nearly attempted suicide? **Yes or No** (circle one). Dates: _____Method:_____

Violence against others (e.g. threats, fights)? **Yes or No** Date(s):_____

Self-harm (e.g. cutting or burning yourself)? **Yes or No** Date(s): _____

Eating Disorder? **Yes or No** Date(s)_____

Name: _____ **Date of Birth:**_____

Medical History:

What was the date of your last physical exam? _____

Do you have now or have you ever had the following medical problems?

PROBLEM	NOW OR PAST?	DETAILS
High Blood Pressure		
Heart Disease or Arrhythmia		
Asthma		
COPD or Emphysema		
Cancer		
Diabetes		
Obesity		
Chronic pain		
Thyroid disorder		
Autoimmune Disorder		
Vision problem		
Hearing problem		
Stomach, esophagus, or intestinal		
Liver Disease		
Skin problem		
Sexual or reproductive problem		
Seizure Disorder		
Stroke		
Dementia		
Head Injury		
Sleep Apnea		

Name: _____ **Date of Birth:**_____

Medical History continued:

Have you ever stayed in a hospital other than a psychiatric hospitalization? **Yes or No** (circle one)

Date:_____ Reason:_____

Have you ever had surgery? **Yes or No** (circle one) Date: _____

Reason:_____

Please list all allergies to medications, food, or the environment: _____

_____

Please list all of your current medications, including over the counter medications, vitamins, supplements:

Name of medication Dose How often do you take it? When was it started? Prescriber

_____

_____

_____

_____

_____

_____

Alcohol and Drug History:

Has anyone ever thought that you might have a problem with alcohol? **Yes or No** (circle one)

Has anyone ever thought that you might have a problem with prescribed drugs? **Yes or No** (circle one)

Has anyone ever thought that you might have a problem with illegal drugs? **Yes or No** (circle one)

Do you use tobacco products? **Yes or No** (circle one)

If so, are you interested in quitting tobacco or nicotine use? **Yes or No** (circle one)

Have you ever received treatment for addiction? **Yes or No** (circle one)

Name: _____ Date of Birth:_____

HOW MUCH DO YOU USE OF THE FOLLOWING SUBSTANCES?		
TYPE	**ROUTE (e.g. oral)**	**AMOUNT (e.g. mg) per Day/Week/Month**
Alcohol		
Tobacco or nicotine or other		
Marijuana (all forms)		
Caffeine		
Pain pills (opiates)		
Sleep pills (e.g. Ambien)		
Benzodiazepines (e.g. xanax, klonopin, valium)		
ADHD meds (e.g. Ritalin, Adderall)		
Cocaine		
Methamphetamines		
Heroin		
Other		

Name: _____ **Date of Birth:**_____

Family history:

Have any of your biological relatives had the following problems? (Check all that apply)

Problem:	Mother	Father	Brother	Sister	Child	Grandma	Grandpa	Aunt/Uncle	Cousin
Depression									
Anxiety									
Bipolar Disorder									
Schizophrenia									
Suicide									
Alcohol or Drug Addiction									
Other psychiatric problem									

Name: _____ **Date of Birth:**_____

Social History:

With whom do you live? _____

What is your marital status? _____ Have you been married previously?_____

How many, if any, children do you have?_____ Their ages?_____

What is your highest level of education?_____

Currently employed? _____ Occupation?_____

Do you have any current legal problems? **Yes or No** (circle one) Details:_____

_____

Have you been charged with any crimes in the past? **Yes or No** (circle one) Details: _____

_____

Have you spent any time in jail or in prison? **Yes or No** (circle one) Details: _____

_____

Have you ever or are you currently on Parole or Probation? **Yes or No** (circle one) Details: _____

_____

Please list any current stressors (e.g. going through divorce, recent move, or started new job)

_____

_____

Do you have guns in your home? **Yes or No** (circle one) _____

_____