Southwest General Medical Group, Inc.

Behavioral Health

Forms & Documents

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	**Ethnicity**	**Student:**
☐ White ☐ Asian ☐ Black/African American ☐ Native Hawaiian ☐ Alaskan Native-American Indian ☐ More than one race ☐ Unreported/Refused	☐ Hispanic ☐ Non Hispanic ☐ Unreported / Refused **Preferred Language :**	☐ 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

Southwest General Medical Group, Inc.

NOTICE OF PRIVACY PRACTICE

Acknowledgement of receipt of notice of privacy practices

I hereby acknowledge that I received the Notice of Privacy Practices of Southwest General Medical Group, Inc. which sets forth the ways in which my electronic personal health information may be used or disclosed by Southwest General Medical Group, and which outlines my rights with respect to such information.

_____ _____ _____

Print Name **Signature** **Date**

Patient DOB _____

1. I would like the person specified below (family member or friend) to have access to my medical information. My signature below gives the doctor and staff of Southwest General Medical Group, Inc my permission to discuss test results and /or my health status with that individual.

_____ _____

Signature **Date**

_____ _____

Specified Person (print name) **Relationship**

OR

2. My signature below indicates that I DO NOT give my permission to release information about my health to anyone other than the insurance company and myself.

_____ _____

Signature **Date**

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibit obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining the acknowledgement

Other (please specify): _____

- ☐ Noted in EHR- consents
- ☐ Scanned into EHR medical record by _____

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) are assessed the full appointment fee.

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

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.

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 non-refillable medications (Concerta, AdderallXR).

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

I have received a copy of the Patient's Rights, Responsibilities and Office Policies. I have been able to ask questions regarding my concerns and I understand my rights, responsibilities and the policies involved in my treatment with Dr. Thysseril, Jeffrey Riskin, L.I.S.W.-S, Cynthia Toncler, L.I.S.W.-S, Daniel Polster, M.D and David Fox, M.D.

_____ _____

Client Signature **Date**

Southwest General Medical Group, Inc.

General Consent for Treatment and Release of Medical Information

Date of Birth: _____ I, _____ ____ _____,
First Name M.I. Last Name

Southwest General Medical Group, Inc. (SGMG) is a multi-specialty group practice. I have received care from one or more SGMG physicians and I hereby voluntarily give my consent to SGMG to provide such diagnostic and medical treatment as deemed necessary.

I authorize SGMG to release any information that may be necessary to comply with subpoenas, governmental regulations and laws. I also authorize SGMG to release to the following parties, any information they request form SGMG regarding treatment I received from any SGMG physician:

- Any insurance company that may be obligated to pay my physician bills
- Medicare or Medicaid (if applicable)
- Any other party who may be obligated to pay my physician bill (example: An employer or HMO)
- Any agent, independent contractor, intermediary or other party who is obtaining information at the request of or for the benefit of any of the foregoing parties

For physician services provided to me, I assign to my SGMG physician and SGMG all insurance or other payments made by other for my physician services. This simply means that any insurance company or other party obligated to pay my physician bills may pay the physician or SGMG directly.

I understand that I am responsible for payment of all bills for any service provided by SGMG physicians. 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 SGMG in establishing a plan for payment of my physician services.

_____ _____/_____
Patient or Responsible Party Signature Date Time

RELEASE OF INFORMATION

I _____, Date of Birth _____give Cynthia Toncler, L.I.S.W.-of Southwest General Medical Group, Inc., Behavioral Health permission to have contact with my Primary Care Provider and/or other Medical providers regarding my psychotherapy visit.

Would you like us to notify your PCP and/or other medical providers that you have begun psychotherapy with Cynthia Toncler, L.I.S.W.? _____Yes or ____No

Name		Phone number & Fax number
1	_____	_____
2	_____	_____
3	_____	_____

This consent is valid through my duration of treatment unless specified otherwise.

_____ _____

Signature of Patient/Parent/Guardian Date

_____ _____

Witness Date

RELEASE OF INFORMATION

I_____ Date of Birth_____

give Dr. Thysseril, Dr. Fox, Dr. Polster, Alison Henton, N.P. Andrew McGill, N.P.,Theresa Backman N.P., or Aasia Syed, M.D. of Southwest General Medical Group, Inc., Behavioral Health permission to have contact with my Primary Care Provider and/or other medical providers regarding a list of medications prescribed and my diagnosis.

Would you like us to notify your PCP and/or other medical providers with a list of your medications and diagnosis? _____Yes or _____No

Name	**Phone number & Fax number**
1._____	_____
2._____	_____
3._____	_____

This consent is valid through my duration of treatment unless specified otherwise.

_____ _____

Signature of Patient/Parent/Guardian **Date**

_____ _____

Witness **Date**

RELEASE OF INFORMATION

I_____, DOB_____ give

Jeffrey Riskin , L.I.S.W.-S of Southwest General Medical Group, Inc., Behavioral Health permission to have contact with my Primary Care Provider and/or other medical providers regarding my psychotherapy visit.

Would you like us to notify your PCP and/or other medical providers that you have begun psychotherapy with Jeffrey Riskin, L.I.S.W.-S? _____Yes or _____No

Name	**Phone number & Fax number**
1._____	_____
2._____	_____
3._____	_____

This consent is valid through my duration of treatment unless specified otherwise.

_____ _____

Signature of Patient/Parent/Guardian **Date**

_____ _____

Witness **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: _____

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	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		

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) _____

_____

Name _____

DEVELOPMENTAL AND MEDICAL HISTORY

PREGNANCY AND DELIVERY

A. Length of pregnancy (e.g., full term, 40 weeks, 32 weeks, etc.) _____

B. Length of delivery (number of hours from initial labor pains to birth) _____

C. Mother's age when child was born _____

D. Child's birth weight _____

E. Did any of the following conditions occur during pregnancy / delivery?

1. Bleeding	No	Yes
2. Excessive weight gain (more than 30 lbs.)	No	Yes
3. Toxemia / preeclampsia	No	Yes
4. Rh factor incompatibility	No	Yes
5. Frequent nausea or vomiting	No	Yes
6. Serious illness or injury	No	Yes
7. Took prescription medications a. If yes, name of medication _____	No	Yes
8. Took illegal drugs	No	Yes
9. Used alcoholic beverage a. If yes, approximate number of drinks per week _____	No	Yes
10. Smoked cigarettes a. If yes, approximate number of cigarettes per day (e.g., ½ pack) _____	No	Yes
11. Was given medication to ease labor pains a. If yes, name of medication _____	No	Yes
12. Delivery was induced	No	Yes
13. Forceps were used during delivery	No	Yes
14. Had a breech delivery	No	Yes
15. Had a cesarean section delivery	No	Yes
16. Other problems – please describe	No	Yes

F. Did any of the following conditions affect your child during delivery or within the first few days after birth?

1. Injured during delivery	No	Yes
2. Cardiopulmonary distress during delivery	No	Yes

3. Delivered with cord around neck	No	Yes
4. Had trouble breathing following delivery	No	Yes
5. Needed oxygen	No	Yes
6. Was cyanotic, turned blue	No	Yes
7. Was jaundiced, turned yellow	No	Yes
8. Had an infection	No	Yes
9. Had seizures	No	Yes
10. Was given medications	No	Yes
11. Born with a congenital defect	No	Yes
12. Was in hospital more than 7 days	No	Yes

INFANT HEALTH AND TEMPERAMENT

A. During the first 12 months, was your child:

1. Difficult to feed	No	Yes
2. Difficult to get to sleep	No	Yes
3. Colicky	No	Yes
4. Difficult to put on a schedule	No	Yes
5. Alert	No	Yes
6. Cheerful	No	Yes
7. Affectionate	No	Yes
8. Sociable	No	Yes
9. Easy to comfort	No	Yes
10. Difficult to keep busy	No	Yes
11. Overactive, in contant motion	No	Yes
12. Very stubborn, challenging	No	Yes

EARLY DEVELOPMENTAL MILESTONES

A. At what age did your child first accomplish the following:

1. Sitting without help _____
2. Crawling _____
3. Walking alone, without assistance _____
4. Using single words (e.g., “mama”, “dada”, “ball”, etc.) _____
5. Putting two or more words together (e.g., “mama up”) _____

(cont.)

6. Bowel training, day and night _____
7. Bladder training, day and night _____

HEALTH HISTORY

A. Date of child's last physical exam: _____

B. At any time has your child had the following:

1. Asthma	Never	Past	Present
2. Allergies	Never	Past	Present
3. Diabetes, arthritis, or other chronic illnesses	Never	Past	Present
4. Epilepsy or seizure disorder	Never	Past	Present
5. Febrile seizures	Never	Past	Present
6. Chicken pox or other common childhood illnesses	Never	Past	Present
7. Heart or blood pressure problems	Never	Past	Present
8. High fevers (over 103°)	Never	Past	Present
9. Broken bones	Never	Past	Present
10. Severe cuts requiring stitches	Never	Past	Present
11. Head injury with loss of consciousness	Never	Past	Present
12. Lead poisoning	Never	Past	Present
13. Surgery	Never	Past	Present
14. Lengthy hospitalization	Never	Past	Present
15. Speech or language problems	Never	Past	Present
16. Chronic ear infections	Never	Past	Present
17. Hearing difficulties	Never	Past	Present
18. Eye or vision problems	Never	Past	Present
19. Fine motor / handwriting problems	Never	Past	Present
20. Gross motor difficulties, clumsiness	Never	Past	Present
21. Appetite problems (overeating or under eating)	Never	Past	Present
22. Sleep problems (falling asleep, staying asleep)	Never	Past	Present
23. Soiling problems	Never	Past	Present
24. Wetting problems	Never	Past	Present
25. Other heath difficulties – please describe	Never	Past	Present