**Welcome to *PETITPAS PSYCHIATRIC SERVICES, LLC.***

We hope that we can give you the kind of support and help that you are looking for. When you receive services, you have the right to:

* Receive high-quality service and be treated with respect and courtesy, be served without discrimination.
* Have your information kept private and confidential except as described in

***Petitpas Psychiatric Services, LLC*** *privacy statement.*

* Receive service in offices that are safe, clean and accessible.
* Get information and support to help you make decisions to improve your situation.

**This is what we ask from you:**

* Treat the staff and others at ***Petitpas Psychiatric Services, LLC***. with courtesy and respect.
* Let ***Petitpas Psychiatric Services, LLC*** know **24 hours in advance**, if you cannot come to an appointment because a **Failure to Keep Appointment Fee is $60.00.**

Upon intake with our office, we provide you with a form entitled, *“Welcome to PETITPAS PSYCHIATRIC SERVICES, LLC.”* This form will be signed and dated by you. This form, which is maintained by our office, constitutes **written legal notice** concerning our fee structure. It clearly states that the following fees are incurred for the following actions:

**Failure to Keep Appointment: $60.00
TDI Form: $10.00
Social Security Disability Reporting: $550.00(full-report) $275.00(Questionnaire-Fee)
Copay and Deductible: Varies according to insurance type**

**Letters: $25.00
Copy of Charts: $25.00
Self-Pay Psychiatric Evaluation: $200.00
Self-Pay Medication Management: $75.00**

**Consulting Psychiatrist:** Dr. Stephen Dizzio M.D., Cushing Street, Providence, RI.

**Controlled Substance Policy:** *A Medication Use Agreement must be signed. Patients who receive controlled substances for* ***ADD or Anxiety*** *must be seen* ***every 4 weeks*** to *continue to receive their medications (no exceptions). Failure to comply with this policy will dismiss you from this practice.*

**Welcome to *PETITPAS PSYCHIATRIC SERVICES, LLC. Continued***

**Fee Explanations for *Petitpas Psychiatric Services, LLC*.**

**TDI Forms:** Fee per each time a patient requires their ***TDI form is a charge of $10.00. This must be paid prior to the completion and faxing of the form.***

**Social Security Disability**: Paperwork at Attorney’s Request. Payment is due prior to the release of the information to the patient or the attorney. **Full Report:** **$550.00**, **Questionnaire Fee:** **$275.00**.

**Copay’s and Deductibles:** Co-pays/Deductibles Must be **paid in full** – failure to do will result in your appointment needing to be rescheduled. Violation of this policy two (2) or more times will jeopardize the patient from being seen in this practice.

**Letters (ex: DCYF, Court, Life Insurance, Housing, Utilities):** Any letter will have a fee of $25.00.

**Copies of Charts:** **$25.00** flat fee.

**Self-Pay Psychiatric Evaluation**: ***$200.00*** **Self-Pay Medication Management**: ***$75.00***

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

\*\**In the case of any debt is due to this practice and if we must send this debt to a third-party collection agency, there will be another* ***$25.00*** *administrative fee added onto what you already owe the practice, and any fees related to the collection of any debt including, but not limited to, reasonable attorney fees and court costs. If you fail to bring your account current,* **the debt will be reported to the appropriate credit reporting bureau and a legal action may be taken to recover said debt**. **Additionally, if your account remains delinquent, we reserve the right to terminate the services that we provide you, if you are still treating with our office.**\*\*\*As this debt is owed to us directly, and we are not a debt collection practice and/or firm, requests to cease contact pursuant to 15 U.S.C. 1692c(c) and 209 CMR 18.14(3) will not be entertained; and collection efforts will persist, in accordance with both state and federal fair debt collection laws, until your account becomes current.

**Patient Information**

**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Age:** \_\_\_\_\_\_**Date of Birth**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**Gender**: Male Female

**Marital Status**: Single Married Divorced Widowed Separated Life Partnered

**Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Place of Employment/School**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Work/School/Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please indicate if we are able to leave messages on these phone numbers:**

**Yes\_\_\_ No\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Primary Ins.:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Subscriber # & Grp. **\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Ins.: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Subscriber# & Grp. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Subscribers Name/Date of Birth/Relationship to yourself: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Emergency Contact/Relationship to you:**

**ER Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Primary Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PCP Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Therapist Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Current Medications**

Please list all current medications that you are taking:

Medication Dose Reason Prescriber Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Patient Allergies**

**Do you suffer from any drug allergies: Yes**\_\_\_\_\_\_\_\_\_\_  **No**\_\_\_\_\_\_\_

If yes which ones: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Patient Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Psychological History**

Place of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Where you were primarily raised (City/State) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was your mother present while growing up? Yes\_\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_\_

Was your father present while growing up? Yes\_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_\_\_\_

Were you ever abused during your childhood? Yes \_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_\_

Verbal\_\_\_\_\_\_\_\_\_\_\_Emotional\_\_\_\_\_\_\_\_\_\_\_Physical\_\_\_\_\_\_\_\_\_\_Sexual\_\_\_\_\_\_\_\_\_\_\_\_\_

How many children were in your family growing up? \_\_\_\_ What number were you? \_\_\_

How far did you go in school? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What kind of work do you do? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Employment:**

Present Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Years at this Job: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Military Service:** Yes\_\_\_\_\_ No\_\_\_\_\_\_\_

If yes, which branch? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dates of Service: \_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_ Type of Discharge: \_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Hobbies & Interests:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 **Patient Information**

**Marital Status**

**Circle and complete**: Married Single Divorced Separated Windowed Life Partnered

How many times have you been married? **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Reason marriage(s) ended? **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**If married, complete the following:**

Spouse’s Age: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Occupation of Spouse: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

How well do you and your spouse (or significant other) get along? (Please check)

Very Poor **\_\_\_\_\_\_\_\_\_\_\_** Fair/Avg**.\_\_\_\_\_\_\_\_\_\_\_** Excellent **\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Describe your relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If widowed, date of your spouse’s death: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Children:**

**Name Gender Age Relationship Living**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Y\_\_\_ N \_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Y\_\_\_ N \_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Y\_\_\_ N \_\_\_

**Developmental History**

Was your mother exposed to specific stressors, drugs, or dangerous substances while she was pregnant with you? Yes\_\_\_\_\_\_ No\_\_\_\_\_\_\_ If yes, what were they? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you have any difficulties in your physical development? Yes \_\_\_\_\_\_ No \_\_\_\_\_\_\_\_

Have you ever been a victim of physical, sexual, or any other kind of abuse?

Verbal\_\_\_\_\_\_\_\_\_\_\_\_Emotional\_\_\_\_\_\_\_\_\_\_\_\_Physical\_\_\_\_\_\_\_\_\_\_\_\_\_Sexual\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been arrested or had legal charges brought against you?

Yes\_\_\_\_\_No\_\_\_\_\_Describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Information**

**Family History**

***Mother:***

**Name Age**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_**

**If deceased, how old was she? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Your age at time of death? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Cause of Death? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How would you describe you or others describe your mother? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How do you get along with her now, if living? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***Father:***

**Name Age**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_**

**If deceased, how old was he?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Your age at time of death? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Cause of Death: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How would you or other describe your father? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How do you get along with your father, if living? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***Brothers and Sisters:***

**How many siblings do you have? \_\_\_\_What number are you in the birth order? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please list their sex and ages:**

**Name Age How do you get along with her/him?**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Describe any useful information about your family: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Information**

**Past Psychiatric/Drug Treatment History**

Have you ever had emotional or psychiatric problems or received treatment before? Yes \_\_\_\_\_ No\_\_\_\_

Have you been treated in the past by a psychiatrist and or therapist? If so, please indicate below:

**Name & Location of Provider Dates of Treatment**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been treated with psychiatric medication? Yes\_\_\_\_\_No\_\_\_\_\_\_\_

\_\_\_\_\_\_ Depression Med Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year: \_\_\_\_\_ Helpful? Yes\_\_\_ No\_\_

\_\_\_\_\_\_ Anxiety Med Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Year: \_\_\_\_\_ Helpful? Yes \_\_\_ No\_\_

\_\_\_\_\_\_ Panic Attacks Med Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Year: \_\_\_\_\_ Helpful? Yes\_\_\_ No\_\_

\_\_\_\_\_\_ Anger Med Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Year: \_\_\_\_\_ Helpful? Yes \_\_\_ No\_\_

\_\_\_\_\_\_ Voices/Visual Med Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Year: \_\_\_\_\_ Helpful? Yes\_\_\_ No\_\_

\_\_\_\_\_\_ Mood Swings Med Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Year: \_\_\_\_\_ Helpful? Yes \_\_\_ No\_\_ \_\_\_\_\_\_Substance Abuse Med Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Year: \_\_\_\_\_ Helpful? Yes\_\_\_ No\_\_

Other Psychiatric Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Psychiatric Medications: Name Dosage Helpful

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Supplements: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any Medication Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been psychiatrically hospitalized? Yes \_\_\_\_\_\_ No \_\_\_\_\_\_\_ Rehab? Yes\_\_\_\_\_\_ No \_\_\_\_\_\_\_

If so please complete the following information for each Hospitalization/Rehab/Day Hospital/Methadone Treatment:

Name of Hospital/Facility Year of Treatment Reason/Diagnosis How Long?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_**

**Past Medical History**

How would you describe your current health? Good\_\_\_\_\_\_\_\_Fair\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Poor\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Medical Problems?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please circle the following past medical history:**

|  |  |  |
| --- | --- | --- |
| **Head Trauma** Yes No | **Heart Problems**Yes No  | **Fractures/Breaks**Yes No |
| **Seizures** Yes No | **Cancer**Yes No  | **HIV Positive** Yes No |
| **Hepatitis** Yes No | **Vascular Problems** Yes No  | **Gastrointestinal Bleeding** Yes No |
| **Cirrhosis** Yes No | **Stroke** Yes No  | **STD**Yes No |
| **Hormonal Problems**Yes No | **Lung Problems**Yes No  |  |

Describe pertinent information regarding your medical or surgical history:

**Family medical history: To your knowledge, have any relatives had any of the following:**

|  |  |  |
| --- | --- | --- |
| **Psychiatric Problems**  Yes No | **Heart Problems**Yes No  | **Musculature/Skeletal Problems** Yes No |
| **Seizures** Yes No | **Cancer**Yes No  | **HIV Positive** Yes No |
| **Hepatitis** Yes No | **Vascular Problems** Yes No  | **Gastrointestinal Bleeding** Yes No |
| **Cirrhosis** Yes No | **Stroke** Yes No  | **Diabetes**Yes No |
| **Hormonal Problems**Yes No | **Lung Problems**Yes No  | **Genitourinary Problems** Yes No  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Mother | Mothers Family | Father | Fathers Family | Brother | Sister | Children |
|  Depression |  |  |  |  |  |  |  |
| Schizophrenia or Manic Depressive Disorder |  |  |  |  |  |  |  |
| Alcohol or Drug Abuse |  |  |  |  |  |  |  |
| Suicide Attempts |  |  |  |  |  |  |  |
| Thyroid Problems |  |  |  |  |  |  |  |
| Anxiety/ Panic  |  |  |  |  |  |  |  |
| Other Psychiatric Illness |  |  |  |  |  |  |  |

**Patient Rights and Responsibilities**

Patricia Petitpas offers access to medically indicated treatment that is available regardless of race, ethnic background, creed, sex, national origin, sexual orientation, age disability, or payment source.

Patricia Petitpas deems the ultimate privilege to be entrusted with the health care of these community’s citizens. We recognize that effective health care involves a partnership between the patient and our practice. Patients who are well informed, participate in treatment decisions, and communicate openly with the Practitioner, also help make the care rendered as effective as possible. The effectiveness of this care and patient satisfaction depends, in part, on both the patient and practitioners fulfilling certain responsibilities.

Every patient has the right to have all information handled in a confidential manner with no information being released without written consent, except in the following case that are required by law: giving proper information to law enforcement or Public health officials, a belief by the provider, using her/his professional judgment, that the individual patient is a victim of abuse, neglect, or domestic violence, or certain legal proceedings.

I have fully read and understood the rights and responsibilities of myself to the practice and its employees.

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_

Witness Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_

**Informed Consent for Treatment and Financial Agreement**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Co-pay: \_\_\_\_\_\_ Deductible: \_\_\_\_\_\_\_\_\_

Secondary Insurance Company (If applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* I understand that Petitpas Psychiatric Services, LLC. Will bill my insurance company/companies with an external or internal billing company. Credit/ Debit cards and cash are accepted.
* **Copayments are due at the time of service**. I agree to pay the required co-pay and deductible at the time of the visit. If there is an inability to make a copayment or a payment in full, I understand I will be rescheduled for an appointment at a later date.
* **Immediate notification to Petitpas Psychiatric Services is expected *if insurance has been changed or canceled. I understand that if my insurance has changed and I have not notified Petitpas Psychiatric Services then I am responsible for any charges that are not paid by the insurance company. I will pay the full amount owed, if my insurance company does not pay Petitpas Psychiatric Services within 90 days.***
* **If paying privately or any “out of pocket” expenses for treatment, I understand that payment will be due at time of my appointment.**
* ***I understand that I must comply with treatment and recommendations while keeping scheduled appointments. I understand that failure to comply with the above may have consequences. Appointments with Petitpas Psychiatric Services may be canceled.***
* I agree to notify Petitpas Psychiatric Services within 24 hours, prior to my appointment, of any cancelation**. I understand that if I miss a scheduled appointment and do not call 24 hours ahead of time to cancel there is a non-refundable $60.00 fee.**
* **If three consecutive appointments are missed, I understand my case will be closed at Petitpas Psychiatric Services, LLC.**
* If it is necessary to speak to Patricia Petitpas, and she is unavailable at the time of your call, please leave a message with office staff with appropriate information and contact number so your call is returned promptly and with accuracy.
* If a situation arises in which Patricia Petitpas has to provide any testimony in court a retaining fee must be paid prior to the actual court date. That fee can be discussed with Petitpas Psychiatric Services, LLC.

**I have read and understand the agreement above and give my consent for treatment with Patricia Petitpas APRN/PCNS-BC/LCDPII.**

**Client Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parent/Guardian Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Witness Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Confidentiality of Client Records**

To our valued Patients:

 The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our practice continually undergoes training so that we may understand and comply with government rules and regulations regarding the Health Insurance Portability Act (HIPPA), with particular emphasis on the “Privacy Rule”. We strive to achieve the very highest standards of ethics and integrity in performing services for our patients. It is our policy to properly determine appropriate uses of PHI in accordance with the governmental rules, laws, and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. We also know that we are not perfect! Because of this fact, our policy is to listen to our contractors and patients without any thought of penalization if they feel that an event in any way compromises our policy integrity. More so, we welcome your input regarding any service problems so that we may remedy the situation promptly. Thank you for being one of our highly valued patients!

 The Department of Health and Human Services has established a “Privacy Rule” to help insure that Personal Health Care Information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patient’s consent for use and disclosures of Health information about the patient to carry out treatment, payment, or health care operations. As our patient, we want you to know that we respect that privacy of your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients) and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent. You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you, should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent to this document, at some future time you may request to refuse all of part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent. If you have any objections to this form, please know you can speak with us about this. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Health Insurance Portability and Accountability Act (HIPPA) protects the confidentiality of client records maintained by the office. Generally, the program may not say to a person outside of the program that a client comes to this practice, or disclose any information identifying a person as a client of the Practitioner unless:

* The client or parent (if the client is under the age of 14 years old) of minor consents in writing
* The disclosure is allowed by a court order
* The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.
* The disclosure is to intervene when someone communicates intent to harm himself/herself/or others. In this event, the targeted individual(s) will be notified, as will appropriate law enforcement officials.
* The disclosure is about suspected child/elder abuse or neglect
* The disclosure is regarding behaviors that place either the client or others in jeopardy while working in what the practice reasonably assumes to be a safety sensitive position

**Client Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parent/Guardian Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Witness:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Authorization for PCP Coordination of Care**

I, **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**, **DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** authorize my Psychiatric Care Practitioner, **Patricia Petitpas, APRN/PCNS**, to release and exchange medical, psychiatric and psychological information with my Primary Care Physician. This information will include the information concerning my diagnosis, treatment plan, appropriate tests and medications.

I understand that I have a right to revoke this authorization at any time. I understand that if I wish to revoke this authorization, I must do so in writing and present my written revocation to my behavioral health clinician as well as my PCP. I also understand that the revocation will not apply to any information that has already been released in response to my authorization prior to this written notice of revocation. I understand the revocation will not apply to my insurance company when the law provides my insurer the right to contest a claim under my policy. I further understand that this authorization will not expire without my written authorization of revocation.

**Signed**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PCP Name & Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Phone :** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Fax:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Authorized Coordination of Care**

**This information is provided to facilitate coordination of treatment/continuity of care.**

**I saw this patient on (date): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Psychiatric Diagnosis: 1.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2.)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **3.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4.)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**The recommended treatment/medication regime is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***Please fax patient’s most recent lab work to 401-944-0196. Thank you!***

Consent to Keep Credit Card on File

Name on card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Billing address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Credit card type: \_\_\_ Visa \_\_\_ Mastercard \_\_\_ Discover \_\_\_\_ AmEx

Credit card number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expiration date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Card ID number: \_\_\_\_\_\_\_\_ (last 3 digits located on the back of the credit card)

Amount to charge: $\_\_\_\_\_\_\_\_\_\_\_\_\_ (USD)

I authorize Petitpas Psychiatric to charge the amount listed above to the credit card provided herein. I agree to pay for this purchase in accordance with the issuing bank cardholder agreement.

Cardholder -- Please sign and date

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_