Professional Psychiatric Services

LAST NAME:_____**FIRST NAME**_____

DOB: ____/____/____

PSYCHIATRIC INTAKE AND TREATMENT PLAN-PART I
TO BE FILLED BY PATIENT
PLEASE PRINT

Date	Age	Gender ☐M ☐F
Current address:		☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed

If patient is a child, he/she live with: ☐ Biological parent ☐ Stepmom ☐ Stepdad ☐ Other:

How did you hear about our services?

Have you experienced any of the following in the PAST or CURRENTLY (WITHIN THE LAST TWO WEEKS)?
Please indicate P for PAST or C for CURRENT for EACH SYMPTOM you have experienced:

P	C		P	C	
☐	☐	depression	☐	☐	increased energy (even when not sleeping)
☐	☐	changes in appetite: ☐ increase ☐ decrease	☐	☐	racing thoughts
☐	☐	sleep disturbance	☐	☐	panic attacks
☐	☐	fatigue	☐	☐	anxiety
☐	☐	low self-esteem	☐	☐	irritability
☐	☐	thoughts of suicide	☐	☐	muscle tension
☐	☐	getting into fights	☐	☐	obsessions (intrusive repetitive thoughts)
☐	☐	wishing you were dead	☐	☐	specific fears or phobias
☐	☐	manic episodes	☐	☐	compulsions (repetitive acts that are unreasonable)
☐	☐	anger	☐	☐	easily distracted
☐	☐	forgetfulness	☐	☐	hallucinations
☐	☐	impulsivity	☐	☐	paranoia
☐	☐	homicide thoughts	☐	☐	mood swings
☐	☐	weight change ☐ increase ☐ decrease	☐	☐	pain, if not receiving treatment would you like a referral: ☐Y ☐N

Other Problems that are not listed above:

When did the problem start?

Have you ever witnessed or experienced a traumatic event that involved death or serious injury? ☐ No ☐ Yes

Details:

Any history of violence? ☐ Against Property ☐ Against People ☐ Only Thoughts of

Details:

Please list all of your current medications including over the counter pills:

Medication	Duration	Dosage	Medication	Duration	Dosage

Are you on birth control? ☐ No ☐ Yes ***Are you pregnant?*** ☐ No ☐ Yes

LAST NAME:_____FIRST NAME_____

DOB: ____/____/____

1. PAST PSYCHIATRIC HISTORY

Have Your Ever Been Admitted To A Psychiatric Hospital: ☐ No ☐ Yes Number of times: ____

Date of Last hospitalization:_____/ _____/_____

Date of First Hospitalization: _____/ _____/_____

Have you seen a psychiatrist? ☐ No ☐ Yes ***How about a therapist:*** ☐ No ☐ Yes

Any history of: ☐ Suicidal thoughts ☐ Suicidal Gestures ☐ Suicide Attempts ☐ History of –self harm/self-mutilation

Please Explain: _____

Have you ever taken any psychiatric medications other than those listed as current? Please list:

Medication	Dates/Duration	Dosage	Response	Reason Discontinued

2. SUBSTANCE ABUSE HISTORY – *please complete if applicable*

	No	Yes/Past or Yes/Now	Route	How Much	How Often	Date/Time of Last Use	Quantity Last Used
Alcohol							
Caffeine (pills or beverages)							
Cocaine							
Crystal Meth-Amphetamine							
Heroin							
Inhalants							
LSD or Hallucinogens							
Marijuana							
Methadone							
Pain Killers							

LAST NAME:_____**FIRST NAME**_____

DOB: ____/____/____

	No	Yes/Past or Yes/Now	Route	How Much	How Often	Date/Time of Last Use	Quantity Last Used
PCP							
Stimulants (pills)							
Tranquilizers/ Sleeping Pills							
Ecstasy							
Nicotine							
Other							

Have you ever been arrested or convicted? ☐ No ☐ Yes: When_____ for (check below):

☐ DWI ☐ Drug Related ☐ Domestic Violence ☐ Other: _____

Please explain: _____

_____

Do you have a P.O? ☐ Yes ☐ No Name: _____ What County? _____

Charge? _____

Please continue to the next page

LAST NAME:_____FIRST NAME_____

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Have you ever been in drug treatment in any of the following settings:

Treatment	Date(s)	Provider's Name	Place of Treatment
Outpatient SA Counseling			
IOP			
Detox Program			
Residential Treatment			
Suboxone Medication			
Other:			

Do you have any concerns about these items below:

1. Decrease in food intake and/ or appetite: ☐ No ☐ Yes (explain): _____
2. Weight loss or gain of 10 lbs. in the last 3 months: ☐ No ☐ Yes (explain): _____
3. Dental Problems: ☐ No ☐ Yes (explain): _____
4. Eating habits or behaviors that may be indicators of an eating disorder, such as binging or inducing vomiting:

   ☐ No ☐ Yes (explain): _____

   Would you like a nutrition referral? ☐ No ☐ Yes
5. Exercise ☐ No ☐ Yes (explain): _____
6. Video games ☐ No ☐ Yes (explain): _____
7. Extreme use of internet, social media, pornography ☐ No ☐ Yes (explain): _____
8. Gambling ☐ No ☐ Yes (explain): _____
9. Other ☐ No ☐ Yes (explain): _____

Professional Psychiatric Services

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3. MEDICAL HISTORY

Allergies: Medication ☐ NONE or LIST :_____

Food ☐ NONE or LIST :_____

Any other Allergies? ☐ NONE or LIST :_____

Are you diagnosed with: ☐ No current medical problems

☐Asthma ☐ High blood pressure ☐Diabetes ☐Heart Disease ☐ Stroke ☐High Cholesterol ☐Thyroid ☐Cancer

☐ **Other Medical problems**: *please list*: _____

_____

History of Surgeries: ☐ No ☐ Yes – Details: _____

History of Head Injury: ☐ No ☐ Yes- **Loss of Consciousness**: ☐ No ☐ Yes _____

History of Seizures: ☐ No ☐ Maybe ☐Yes _____

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4. FAMILY PSYCHIATRIC HISTORY – *Any one in your family suffers from*:

☐Depression ☐Anxiety Disorder ☐ Bipolar disorder ☐Alcoholism ☐Drug Abuse ☐ Schizophrenia ☐Suicide ☐Homicide

Details: _____

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5. SOCIAL HISTORY

Birthplace: _____ # of Siblings:_____ Birth order: _____ Occupation of Mother: _____
Father: _____

History of Abuse: ☐No ☐Yes If yes, was it (circle all that applies) ☐verbal ☐physical ☐sexual
Details: _____

Who raised you: _____ How was your childhood? _____

How far did you go in school? GED: ☐ No ☐Yes High School: ☐ No ☐Yes
College: _____ Post Grad: _____

Have you skipped a grade: ☐ No ☐ Yes Were you in Special Education: ☐ No ☐ Yes

Problems in school: ☐ No ☐ Yes *Explain*: _____

What do you do for a living? _____ **Current Employment**: _____

Marital Status: ☐Married ☐ In a relationship ☐Single ☐ Divorced ☐Separated ☐Widowed # of Children: _____

Sexuality: ☐Heterosexual ☐Homosexual ☐Bisexual **Military Experience**: ☐ No ☐ Yes _____

Who do you live with?_____

Current Social Support: _____

Spirituality: _____

Hobbies / Interests: _____

6. CURRENT HEALTH CARE PROVIDORS: For Permission to Contact any of them, Please check the appropriate box:

PREVIOUS PSYCHIATRIST: _____ ***Phone (____)____ - ____***

Address: _____ **Contact:** ☐ No ☐ Yes

CURRENT PSYCHOTHERAPIST/COUNSELOR: _____ ***Phone (____) ____ - ____***

Contact: ☐ No ☐ Yes

CURRENT PRIMARY CARE PHYSICIAN: _____ ***Phone (____)____ - ____***

Address: _____ **Contact:** ☐ No ☐ Yes

OTHER: _____ ***Phone (____)____ - ____***

Address: _____ **Contact:** ☐ No ☐ Yes

7. Treatment Goals: (What would you like to achieve from visiting the clinic, please list according to their importance)

(1)

(2)

(3)

Is there anything else you would like to tell us about yourself?

_____

_____

_____

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

Form Filled Out by:

_____ _____ _____ _____

(Print Name) (Signature) (Date) (Relationship to Patient)

Patient or Parent/Guardian of child under the age of 18 must sign above.

This form has been reviewed for completion and accuracy.

_____ _____ _____

(Print Name) (Signature) (Date)

This form has been reviewed by the provider for evaluation purposes.

_____ _____ _____

(Print Name) (Signature) (Date)

Notice of Professional Psychiatric Services
General Office and Financial Policies

Patient Name:_____ **D.O.B.**_____/_____/_____

We believe it is in the best interest of your care to keep you informed of our office policies. Please carefully read each item below and initial each item if you do not have any questions, followed by your signature at the bottom of page 2. If you have any questions, our staff will be happy to help.

1. All patients who do not have commercial insurance, or have insurance that we are not contracted with, are expected to pay in full at the time services are rendered._____**(initial)**

2. For all patients with a commercial insurance policy for a carrier we are contracted with, we will file with your primary insurance company and accept payment per our contracted rate. We will file to your secondary claim up to two times. If we have not received payment after the second filing, the balance will become patient responsibility. You must file your tertiary insurance claims yourself. For any services rendered which are unbillable to your insurance; you will be notified in advance, and payment from the patient is expected at the time of service _____**(initial)**

3. Prior to your visit at our office, we will contact your insurance company to verify your benefits under your plan. Please remember that each individual plan is different so we will never know exactly how your insurance will pay your claim until it is processed by your insurance company. With the information you provide, we will be able to determine the approximate payment due at the time services are rendered as well as learn of any authorizations required by your plan. _____**(initial)**

4. You agree to provide our office with any changes in insurance. You agree to provide us with a copy of your insurance card any time there is a change. If we do not have the correct insurance information on file, you will be responsible for the full amount owed. _____**(initial)**

5. If you have a copay, it must be paid in full at the time of your visit. This is in accordance with your insurance agreement. If you have a deductible and it has not yet been satisfied, you must pay 100% of the billed charges at the time of your visit. If you have a co-insurance plan, you will be charged a percentage of the billed charges for your visit. _____**(initial)**

6. In the event of an overpayment, you may choose to have the funds refunded to you or we can apply them to future dates of service. However, refunds less than $100.00 will not be issued if there are outstanding insurance claims. _____ **(initial)**

7. In the event of a balance due, we request that payment and/or arrangements be made within 30 days. The office will mail out statements monthly. It is your responsibility to ensure that we have the correct address on file. Our office will also keep you informed of any balance you may have. It is our policy that the ability to receive services might be suspended if your current balance exceeds $200 unless a payment agreement is in writing and is approved by the office manager to overcome the unpaid balance. If you have a question regarding your balance, please contact the billing department. _____ **(initial)**

8. Please remember that, just as PPS has a contract with your insurance company, you do as well. In order for us to be contractually obligated to accept the payment and discounts your insurance offers you, you must follow the guidelines set forth by your insurance carrier. It is your responsibility to participate in the insurance guidelines, which includes prompt payment of services rendered, or your contract may be voided. **____ (initial)**

Patient Name:_____ **D.O.B.**_____/_____ /_____

9. Visit Authorizations: PPS will keep track of the number of visits in regards to any authorizations required by your insurance. However, please be aware that this is also your responsibility. You are required to know the benefits of your plan, the number of visits allowed, and if further authorizations are required. _____ **(initial)**

10. Appointment Reminders: As a courtesy, PPS will set up automated appointment reminders. You will receive a reminder text at least 48 hours prior to your upcoming appointment. It is your responsibility to provide PPS with the correct phone number for the automated texts. Therefore, our no show/late cancel policy is strictly enforced. You will be charged $60.00 per missed visit/ late cancel visit unless you call us 24 hours before your appointment. _____ (**initial)**

11. Re-establishing services: If you are not seen at the regularity of your provider's request or within a 3-month window, you will be considered discharged from the agency and will be required to re-establish as a new patient if you want to restart services. If you are participating in our OMT program and are not seen in over a month you may be required to re-establish as a new patient. _____ **(initial)**

12. Form Requests / Medical Records: If you need forms completed or records sent outside of the office, we will be happy to do so. You will need to schedule a specific paperwork appointment in order to get forms completed by your provider. Records requests will be executed within 30 business days of your signing the release form. *Please ask staff for a Release of Information Form*. There is a charge per page and/or per request. There is an additional fee if you need the request expedited. All of these charges are in line with industry standards, and are usually not covered by your insurance. Payment is expected for these services at the time of the request. _____ **(initial)**

By signing below, I agree that I have ready and understand the financial policies above. I understand that I am responsible for all charges that are not covered by my insurance, an in the event of a no show/late cancel or form requests/medical records request; these charges are completely my responsibility and my insurance carrier/third party payor will not be billed.

_____ _____ /_____/ _____

Patient Printed Name **Date**

_____

Patient / Parent / Legal Guardian Signature

PATIENT INFORMATION

DATE: _____

Patient's Name: _____ Date of Birth: _____
Street Address: _____ City_____ State: _____ Zip:_____
Cell Phone # : ( ) _____ Home Phone #: ( ) _____ Work # : ( ) _____
Social Security #: _____ *Sex*: ☐ M ☐ F Marital Status: _____ Race: _____
Patient's Employer: _____ Occupation: _____
Contact in Case of Emergency: _____ Phone # : ( ) _____
Family Doctor: _____ Referring Doctor: _____

Preferred Contact Phone #: ( ) _____ PPS may leave PHI on my answering machine /voicemail: ☐Yes ☐No
PPS may leave the following: ☐appointment information ☐ detailed information ☐ test or lab results ☐ response to my inquiry /question
Email Address: _____ PPS may email appointment reminders: ☐Yes ☐No

Insurance Information: Please give receptionist your card(s)
Primary Insurance: _____ Phone #: ( ) _____
Insured Name: _____ Relation to Patient: _____
Insured Policy ID#: _____ Group # : _____
Insured DOB: _____ Insured Employer: _____ Insured S.S.#: _____
Insurance coverage provided through ☐ Employer ☐ Individual Policy ☐ Workers Comp ☐ Auto Accident Policy
Secondary Insurance: _____ Phone #: ( ) _____
Insured Name: _____ Relation to Patient: _____
Insured Policy ID#: _____ Group # : _____
Insured DOB: _____ Insured Employer: _____ Insured S.S.#: _____
Insurance coverage provided through ☐ Employer ☐ Individual Policy ☐ Workers Comp ☐ Auto Accident Policy
If Medicare is secondary circle reason: ☐working ☐ spouse has insurance ☐ Veteran ☐ disabled ☐ other: _____

If Patient is a Minor:
Mother's Name: _____ Date of Birth: _____ Home PH # ( ) _____
Mother's Employer:_____ Bus. PH #: ( ) _____ Social Security # :_____
Father's Name: _____ Date of Birth: _____ Home PH # ( ) _____
Father's Employer:_____ Bus. PH #: ( ) _____ Social Security # :_____

Please read and sign below:
I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize my physician to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare/insurance claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to my physician on claims for which they have accepted assignment and I authorize the physician to submit a claim to Medicare for payment on my behalf. I request payment under the medical insurance program be made to my physician on any bills for services furnished me by my physician for which they have accepted assignment. I further release my physician to release medical information concerning my treatment to Blue Shield or other insurance carriers and authorize payment of medical benefits from those carriers to be made directly to my physician on claims for which they have accepted the assignment. I also understand that I am responsible for payment for services not covered by the Medicare program or my insurance carrier.

I also authorize my physician's office to provide my medical information to other organizations or entities for the determination and payment of benefits. I authorize my physician's office to permit my insurance companies or third party payors to review / audit my medical chart if they so request. I assign benefits otherwise payable to me to my physician. I understand that I am financially responsible for the charges for any services rendered to me by my physician(s).

I have reviewed the practice's **PRIVACY POLICY** _____ (INITIAL HERE)
I have reviewed the **OFFICE FINANCIAL POLICY** _____ (INITIAL HERE)
I have reviewed the **CONSENT for TREATMENT** _____ (INITIAL HERE)
I understand that copies are available upon request.

Signature: _____ Date: _____
If this is a worker's compensation visit or auto accident account we must have that information on an additional form. Please ask the receptionist for the appropriate paperwork.
PRIVATE INSURANCE REQUIRES A COPAY TO BE PAID AT THE TIME OF SERVICE, if applicable.

By signing below, I acknowledge that after I sign in, I MUST NOT leave the building while waiting to complete my UDS screen. I understand that if I leave the building once I have signed in for my UDS screen, I could be automatically failed and discharged from the office/program. I also understand that if I need "time" to complete my UDS screen, I must wait in the large waiting room until I am able. When ready, I will go to the check in window to notify the front office staff that I am ready to complete my UDS screen and will go to the small UDS waiting room.

I also acknowledge that if I refuse to complete my UDS screen, I could be discharged from the office/program.

Printed Name	Signature	Date

Professional Psychiatric Services OMT Financial Policies

We believe it is in the best interest of your care to keep you informed of our office policies. Please carefully read each item below and initial, followed by your signature at the bottom of the page. If you have any questions, our staff will be happy to help.

- I fully understand that payment for services provided by Professional Psychiatric Services is totally my responsibility.
    - I will pay $160.00 for the initial evaluation and $150.00 for all follow up visits. The frequency of follow up visits will be scheduled based on my compliance with the treatment.

- I understand that urine drug screens (UDS) are a part of the program requirement. I will be responsible to pay $10.00 for each UDS that is performed in the office.

- PPS will set up automated appointment reminders so you receive a reminder at least 48 hours prior to your upcoming appointment. Therefore, our no show/late cancel policy is strictly enforced. You will be charged $60.00 per missed visit unless you call us 24 hours before your appointment.

- The ability to receive services might be suspended if my current balance exceeds $200 unless payment agreement is discussed with the office manager to overcome the unpaid balance.

By signing below, I agree that I have ready and understand the financial policies above. I understand that I am responsible for all charges.

Signature: _____ _ Date: ------

OPIOID MAINTENENCE TREATMENT (OMT) CONTRACT

Patient Name: _____ Date: ___ /_____/__ _

As a participant in buprenorphine treatment for OMT, I freely and 11oluntarily agree to accept this treatment contract as follows. Any violation o fany o fthe items below could lead to termination o fthe OMT program. ***(Please initial before each item and sign on page 2):***

— I agree to keep and be on time to all my scheduled visits as planned by my OMT physician. The scheduling o fmy follow up visits is subject to change by my psychiatrist based on UDS results or any information that might prompt my psychiatrist to increase the frequency o fmy visits.

- I agree to adhere to the financial policy outlined by this office in exhibit A.

- I agree to conduct myself in a courteous manner in the doctor's office.

- I agree not to sell, share, exchange or give any o fmy medication to another person. I understand that such mishandling o fmy medication is a serious violation o fthis agreement and would result in my treatment being terminated without recourse for appeal.

- I agree not to deal, steal or conduct any illegal or disruptive activities in the doctor's office.

- I agree that my medication/prescription can Ol).ly be given to me at my regular office visits. Losing / damaging my prescription for any reason does not guarantee the office will re-issue another one.

- I agree that the medication that I receive is my responsibility and I agree to keep it in a safe, secure place. I agree that lost medication will not be replaced regardless o fcause o floss.

- I agree not to obtain medication from any doctors, pharmacies, or other sources without discussing it with my OMT psychiatrist before having it dispensed by the pharmacy.

- I understand that mixing buprenorphine with other prescribed medications; such as benzodiazepines (for example, Valium, Klonopon, or Xanax) or stimulants (for example, Adderall, Ritalin for ADD or any weight loss medications) can be dangerous unless it is prescribed by a physician and consulted with an addiction psychiatrist as required by the Ohio Medical Board. These controlled substances must show on your OARRS report and on the Urine Drug Screen.

- I agree to take my medication as my OMT psychiatrist has instructed and not to alter the way I take my medication without first consulting my OMT psychiatrist. If you do so, you might run out of medication sooner, which could expose you to relapse.

- I understand that medication alone is not sufficient treatment for my condition, and agree to participate in professional counseling with PPS or with an outside counselor as discussed and agreed upon with my doctor and specified in my treatment plan. If it is agreed that I will participate in outside professional counseling I will need to bring in proof after each visit which will be placed in my chart.

OPIOID MAINTENCE TREATMENT (OMT) CONTRACT page 2

Patient Name: _____ Dat : ___ /_____/__ –

- I agree to abstain from any illegal substances. I agree to abstain from using, seeking, obtaining any opioid containing medication, including cough syrup even if it was prescribed by an outside physician for a legitimate medical reason unless a written approval by PPS OMT physician is obtained **BEFORE** engaging in this process (getting opioid prescription).

- I agree to abstain from drinking any amount of alcohol while I am on the OMT program. Mixing alcohol with buprenorphine could suppress my breathing while sleeping and result in death due to respiratory failure.

- I agree to random urine drug screens and pill counts to ensure compliance. I understand I could be called to report to the office for random urine drug screens and pill counts; failure to report at the appointed time is subject to termination from the program.

- I understand I will need to keep my contact information, especially my cell phone number, up to date with PPS. Failure to do so might lead to loss· or delayed communication between you and PPS regarding compliance with the program which could be a reason for service termination.

- I agree to call 911 or go to the nearest emergency room if any medical urgency or emergency may arise from terminating services with PPS OMT program due to my non-compliance.

- I understand that violations of the above may be grounds for termination of treatment.

_____ _____/___ /__ _
Patient Signature Date

Upon review of the treatment contract I give my Consent to Treatment

I hereby certify that Professional Psychiatric Services Physician, C,inician or Independent Contractor providing services has informed me of their professional qualifications, certifications and/or licensure; has provided both an explanation of client's rights and responsibilities, has made the privacy notice available and has informed me of their assessment, diagnosis, and treatment plan.

By signing below, I agree to participate in the proposed treatment as recommended.

_____ _____
Patient Signature Date Physician, Clinician or Independent Contractor Date

__ _/_____/_____ _____
Date of Birth Social Security #

Professional Psychiatric Services

PATIENT NAME: _____

DOB: _____/_____/_____

SS#: _____

CONSENT TO TREAT

I hereby certify that Professional Psychiatric Services Physician, Clinician or Independent Contractor providing services has informed me of their professional qualifications, certifications and/or licensure; has provided both an explanation of client's rights and responsibilities, has made the privacy notice available and has informed me of their assessment, diagnosis, and treatment plan. By signing below, I agree to participate in the proposed treatment as recommended.

_____ _____

Patient Signature Date Physician, Clinician or Independent Contractor Date

If treatment is for a minor,

I _____ custodial parent / legal guardian of:
(Name of parent/legal guardian)

_____, age _____, authorize
(Name of Minor) (Age of Minor)

Professional Psychiatric Services to assess and treat my child in an outpatient mental health setting. I agree to take part in the process as needed, and understand the forma of treatment nay include any combination of the following: individual sessions with minor child, family sessions and sessions with parental unit(s).

_____ _____

Parent/Legal Guardian Signature Date Physician, Clinician or Independent Contractor Date

Elective Self-Pay Agreement

Patient Name: ---------- Patient DOB: __ /__ /__

☐ By checking this box you understand that you are being billed for any services you may receive at Professional Psychiatric Services.

I am agreeing to pay personally out of pocket and electing not to have my insurance billed. I agree to be personally and fully responsible for any and all charges accrued related to the delivery of any services received. I also understand that I may not go back and choose to have a previous session switched from Self Pay to Insurance billed charges.

I understand and agree to the above stated terms. I understand that these sessions/therapies may be considered covered by my insurance policy and filing is done as a courtesy to me, I have chosen to opt out of this option. If I have questions about my bill I can contact the billing department at 513-229-7585 option 6 and talk with a billing representative.

Signature of Patient/Guardian _____ Date _____

Printed Name of Patient/Guardian _____ Date _____

Witness _____ Date _____

Phone: [513) 229-7585
9117 Cincinnati Columbus Rd
West Chester, OH 45069

Fox: (513) 229-7731
Website: www.ppsych.com