JAFFERANY PSYCHIATRIC SERVICES

1184 Cleaver Road
Caro MI 48723
Phone: 989-286-3330
Fax: 989-286-3332

PATIENT DATA SHEET

☐ Initial ☐ Update

Name: | Account:

PATIENT INFORMATION

Full Name: _____
Last First Middle Initial Suffix
Street Address: _____
City / State / Zip: _____
Phone Numbers: Cell:_____ Home :_____Work: _____
E-Mail Address: _____
DOB: _____Age: _____ Gender: ☐ M ☐ F Race_____
Marital Status: _____Employment Status: _____Education: _____
Source of Referral: _____

EMERGENCY CONTACT INFORMATION

Name: _____Relationship: _____

Address: _____Phone: _____

CONFIDENTIAL COMMUNICATION INFORMATION

Do you have concerns with our office telephoning you at home or sending mail to your home?
☐ Yes ☐ No Patient Comments: _____

ONLY if the answer is YES, complete the information below:

1. May postcards/letters, which identify our facility (Jafferany Psychiatric Services) be sent to this address: ☐ Yes ☐ No
2. What is the address for written confidential communication, if different than the address listed above? _____
3. Is there an alternative phone number to be used for communication? ☐ Yes ☐ No
4. If YES to #3, what is the alternative telephone number? _____
5. If YES to #3, what time(s) may we call? _____
6. May our staff/facility leave a message at this phone number? ☐ Yes ☐ No
7. May this message include the name of our facility/staff? ☐ Yes ☐ No
8. May we leave a blind message with our phone number only? ☐ Yes ☐ No

PERSONAL/LEGAL REPRESENTATIVE INFORMATION (IF APPLICABLE)

Representative Name: _____ Relationship: _____
Address: _____Phone: _____
Do you have proof of power of attorney / guardianship with you? ☐ Yes ☐ No

Patient Signature: | Date:

**Note: When a patient indicates that changes have occurred since his/her last appointment, then reassess the patient's preference for confidential communication.*

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CHILD/ADOLESCENT INTAKE FORM

PATIENT INFORMATION

Name: _____
First Last

Date of Birth: _____ Age: _____ Gender: _____ Race: _____

Address: _____
Street City State Zip

PARENT CONTACTS

Mother's Name: _____ Age: _____
First Last

Father's Name: _____ Age: _____
First Last

Marital Status of Parents: (circle) Single Married Cohabiting Divorced Separated Widowed

Mother's Address: _____
Street City State Zip

Contact phone number(s): _____
Home Cell Work

Father's Address: _____
Street City State Zip

Contact phone number(s): _____
Home Cell Work

If divorced, who has legal custody? _____

Who has physical custody? _____

What is the schedule for parenting time? _____

_____

REFERRAL INFORMATION

Who referred you to this practice? _____
(Name)

_____
(Address)

_____
(Phone) Fax)

PRESENTING PROBLEM

What is the **PROBLEM** for which you are seeking assistance for your child/adolescent?

What concerns you most about your child/adolescent?

When did you first notice this problem?

What caused you to seek assistance at this time?

How has this problem affected his/her functioning? At home:

At school/work:

In the community:

Do you have other concerns that you would like addressed?

What are your goals/expectations for treatment?

Have you recently worried that your child/adolescent has any of the following? **(IF YES, PLEASE CIRCLE EACH INDIVIDUAL ITEM THAT IS RELEVANT TO HIM/HER.)**

☐Yes ☐No **DEPRESSION** (sad, irritable, hopeless, helpless, crying, difficulty sleeping, sleeping too much, decreased energy/fatigue, feelings of worthlessness or guilt, difficulty thinking or concentrating, difficulty making decisions, social withdrawal / isolative behaviors, lack of interest in things, suicidal thoughts)

☐Yes ☐No **MOOD SWINGS** (energetic, little sleep, pleasure seeking, racing thoughts, too talkative, inappropriate sexual behaviors, grandiose, etc.)

☐Yes ☐No **ANXIETY** (worries, restless, scared, poor sleep, obsessive thoughts and/or compulsive behaviors, frequent complaining of headaches and/or stomach aches, frequent school / work absences, etc.)

☐Yes ☐No **BEHAVIORAL PROBLEMS** (fights/physical aggression, anger, arguing, destruction of property, fire setting, hurting animals, etc.)

☐Yes ☐No **ATTENTION / HYPERACTIVITY PROBLEMS** (difficulty paying attention, easily distracted, difficulty completing tasks, hyperactive, impulsive)

☐Yes ☐No **ABNORMAL EATING BEHAVIORS** (too much/significant weight gain, too little/significant weight loss, fear of weight gain, distorted body image, excessive exercising, etc.)

☐Yes ☐No **SOCIAL ANXIETY** (shy and/or afraid to be around others, fear of being judged by others, avoidance of crowds, avoidance of public places)

☐Yes ☐No **REMEMBERING PAST TRAUMAS** (frequent nightmares, intrusive and/or recurrent memories, etc.)

☐Yes ☐No **AUTISM** (social and language impairments, rigidity)

☐Yes ☐No **PSYCHOSIS** (hearing voices, seeing things, paranoia, delusions)

☐Yes ☐No **DISSOCIATION** (feeling outside his/her body or like things are not real, etc.)

☐Yes ☐No Has your child/adolescent ever **HARMED HIM/HERSELF INTENTIONALLY**? If yes, please explain: _____

☐Yes ☐No Has your child/adolescent ever **ATTEMPTED SUICIDE**? If yes, please explain: _____

_____

☐Yes ☐No Has your child/adolescent ever **HARMED OTHERS**? If yes, please explain: _____

_____

☐Yes ☐No Has your child/adolescent ever been the **VICTIM OF ABUSE OR NEGLECT**? If yes, what was the nature of the abuse/neglect? _____

_____

☐Yes ☐No Has your child/adolescent experienced a **SIGNIFICANT LOSS**? If yes, please explain:

_____

☐Yes ☐No Has your child/adolescent experienced any **PROBLEMS RELATED TO RACE, RELIGION, OR CULTURE**? If yes, please explain: _____

_____

Has your child/adolescent ever been involved with the following? If yes, please explain:

☐Yes ☐No Child Protective Services: _____

☐Yes ☐No Probation / Juvenile Probation / Detention / Police: _____

_____

MENTAL HEALTH HISTORY

OUTPATIENT TREATMENT for your child/adolescent:

	Name	Location	When (month/year)?	For how long?
Psychiatrist:				
Therapist:				

PSYCHIATRIC HOSPITALIZATIONS for your child/adolescent (residential or day treatment programs, including any alcohol and drug treatment programs):

Where	When (month/year)	Length of Stay	Type of Treatment	Diagnosis

CURRENT PSYCHIATRIC MEDICATIONS for your child/adolescent:

Name	Dosage	When Prescribed	Prescribed By	Response

PREVIOUS PSYCHIATRIC MEDICATIONS for your child/adolescent (if greater than 6 medications, please attach separate list):

Name	Highest Dosage	Duration	Response	Reason for Stopping

SUBSTANCE USE of your child/adolescent:

	Type	Average Usage	Current	Past	When Last Used
Caffeine			☐	☐	
Nicotine			☐	☐	
Alcohol			☐	☐	
Marijuana			☐	☐	

Type	Average Usage	Current	Past	When Last Used
Inhalants		☐	☐	
Hallucinogens (LSD/Ecstasy/PCP/Mushrooms)		☐	☐	
Opiates (Heroin/Morphine/Other Narcotics)		☐	☐	
Sedatives		☐	☐	
Steroids		☐	☐	
Stimulants (Meth/Crack/Cocaine/Crank)		☐	☐	
Synthetic Drugs/Bath Salts		☐	☐	
Misuse of Other Prescription Drugs		☐	☐	

PREGNANCY AND BIRTH HISTORY

How old were this child's biological parents when he/she was conceived? _____
Baby's birth weight and length: _____
Length of pregnancy (in weeks): _____

Did you take any medication (prescription and over the counter) during this pregnancy?_____
(If yes, please complete the following table.)

Medication	Month(s) Taken (1-9)	Reason for Taking

Did you consume alcohol during this pregnancy? _____ If yes, how much and how often?_____

Did you smoke or use tobacco products during this pregnancy? _____ If yes, how much and how often?

Did you use any drugs during this pregnancy? _____ If yes, please name drug(s), how much, and how often used: _____

Were there any problems with the baby's health right before or immediately after delivery? _____
If yes, please describe: _____

Apgar Scores: _____

DEVELOPMENTAL HISTORY

At what age did your child achieve the following milestones?

_____ Language (first using words, sentences, etc.)?_____

_____ Fine Motor Skills (building towers with cubes, drawing circles)?_____

_____ Gross Motor Skills (rolling over, standing, walking)?_____

_____ Daytime Toilet training? _____

_____ Nighttime Toilet training? _____

Has your child experienced any regression of these? _____ If yes, explain: _____

_____

_____

SOCIAL HISTORY

Is your child/adolescent your biological child? _____If no, at what age was he/she adopted? _____

Is there any contact with his/her biological parents? _____

Where was your child/adolescent born and raised? _____

FAMILY MEMBERS: (including parents, stepparents, siblings, stepsiblings and half-siblings)

Name Age Lives at Home? Relation to Child Quality of Relationship with Child

_____

_____

_____

_____

_____

_____

_____

Who disciplines your child & what kind of discipline is used? _____

_____

Do you have a religious preference in the household? _____ If yes, what is that preference?_____

_____

Do you have an ethnic heritage that is an influence on your child's life? _____If yes, please explain:_

_____

SCHOOL:

Where does your child/adolescent attend school? _____

In what grade level is he/she? _____

What are his/her typical grades? _____

What are your child's academic strengths? _____

_____

Academic weaknesses? _____

_____

Has there been a change in your child's performance at school? _____If yes, please describe: _____

_____

_____

Has your child received IQ or Academic Testing? _____ If yes, what were the results? _____

_____

Has your child participated in any of the following? If yes, please explain:

☐ Yes ☐ No Resource Room (for which classes/how many hours?) _____

_____

☐ Yes ☐ No Gifted, Accelerated, or Honors programs _____

_____

☐ Yes ☐ No 504 Plan: _____

☐ Yes ☐ No Individual Education Plan (IEP):_____

☐ Yes ☐ No Head Start:_____

☐ Yes ☐ No Early Intervention Services (ages 0-3) or Birth through Five:_____

_____

Has your child had problems with any of the following? If yes, please explain:

☐ Yes ☐ No Truancy _____

☐ Yes ☐ No Fights _____

☐ Yes ☐ No Absenteeism _____

☐ Yes ☐ No Detention _____

☐ Yes ☐ No Suspension _____

☐ Yes ☐ No School refusal _____

PEERS:

Does your child/adolescent have quality relationships with other children/adolescents? _____ If not, please explain: _____

_____

Has your child/adolescent had a recent change in friendships? ____If yes, what changes, if any, are of concern to you? _____

_____

_____

Do you have any concerns regarding your child/adolescent's friendships?

☐ Too Old	☐ Too much time together	☐ Drug/Alcohol Use
☐ Too Young	☐ Truant	☐ Violence
☐ Too Many	☐ Gang	☐ Sexual Promiscuity
☐ Too Few	☐ Fringe	☐ Other: _____

Is your child/adolescent sexually active? _____If yes, are you concerned about your child/adolescent's sexual activities?_____

Does your adolescent have a job?_____ If yes, explain: _____

_____

What are your child/adolescent's hobbies/interests? _____

_____

_____

FAMILY MENTAL HEALTH HISTORY

Consider your child's immediate family and all of his/her relatives on both sides. (Maternal is mother's side of the family and Paternal is father's side of the family.) Include parents, brothers, sisters, aunts, uncles, grandparents, and 1st cousins. Review the list below. If any relative has one of these disorders, check it and describe his/her relation to your child/adolescent and his/her treatment history (if applicable).

_____ Depression _____
_____ Anxiety _____
_____ ADHD _____
_____ Bipolar (manic depressive) _____
_____ Schizophrenia _____
_____ Alcohol Problems _____
_____ Drug Problems _____
_____ Learning Disabilities _____
_____ Autism / Asperger's /Pervasive Developmental Disorder _____
_____ Mental Retardation/Intellectual Disability _____
_____ Nervous Breakdown _____
_____ Psychiatric Hospitalizations _____
_____ Suicide attempts _____
_____ Completed suicide _____
_____ Panic Disorder _____
_____ PTSD (Post Traumatic Stress Disorder) _____
_____ OCD (Obsessive Compulsive Disorder) _____
_____ Seizures _____
_____ Other _____

MEDICAL HISTORY

PRIMARY CARE PROVIDER _____
Address: _____
Phone: _____ Fax: _____
When was his/her last physical exam with bloodwork? _____
Are there other physicians/specialists your child sees on a regular basis?_____

_____

_____

CHECK IF YOUR CHILD/ADOLESCENT HAS EVER HAD:

☐ Loss of Consciousness ☐ Head Injury ☐ Seizures

CHECK IF YOUR CHILD/ADOLESCENT HAS ANY OF THE FOLLOWING:

☐ Allergies
☐ Anemia/ Low Iron
☐ Arthritis
☐ Asthma
☐ Bedwetting/Toilet Issues
☐ Back or Neck Pain
☐ Chronic Nosebleeds
☐ Diabetes
☐ Hearing Problem
☐ Heart Problem
☐ High Blood Pressure
☐ High Cholesterol
☐ IBS/Crohn's Disease/Celiac Disease
☐ Kidney Disease
☐ Liver disease
☐ Menstrual Problems
☐ Migraine Headaches
☐ Obesity
☐ Skin Conditions/Eczema/Dermatitis
☐ Stomach problems
☐ Thyroid problems
☐ Vision Problems

☐ Cancer If yes for cancer, what type and any required treatment? _____

_____

_____

☐ Surgeries If yes for surgeries, what type? _____

_____

_____

Are there any other medical problems not listed above? If so, please list here: _____

_____

_____

CURRENT <u>NON-PSYCHIATRIC</u> MEDICATIONS:

Name Dosage When Prescribed Response

_____

_____

_____

_____

Drug Allergies and Reactions: _____

_____

_____

Signature:_____ **Date:** _____

(*Please Circle*: Parent/Guardian/Other_____)

Signature:_____ **Date:** _____

(*Please circle*: Adolescent/Child)

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CONSENT FOR TREATMENT

I consent to treatment for myself or for the patient for whom I am the parent, guardian or legal representative. I understand that Jafferany Psychiatric Services will share patient health information according to federal and state law for treatment, payment, and operations.

I understand that the patient is responsible for all charges incurred, regardless of the patient's insurance status. The patient agrees to pay for services as the patient incurs the charges. I authorize the insurance provider to pay **Jafferany Psychiatric Services** for services rendered.

_____ _____

Patient Signature Date

_____ _____

Parent/Guardian/Legal Representative Signature Date

_____ _____

Witness Signature Date

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CONSENT TO THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS

I hereby acknowledge receipt of a written notice of my privacy rights and I consent to Jafferany Psychiatric Services using and disclosing my protected health information to carry out treatment, payment, or health care operations.

I understand and have been provided with a "Notice of Privacy Practices", which provides a more complete description of how my protected health information may be used or disclosed. I understand that I have the right to review the notice prior to signing this consent.

I understand that Jafferany Psychiatric Services reserves the right to change their notice and information practices and that I may obtain a copy of the revised notice by written request addressed to Jafferany Psychiatric Services, 1184 Cleaver Rd., Caro, MI 48723.

Due to the sensitive nature of psychiatric records, as opposed to family physician records, we do not release records to patients directly. However, these records may be sent/shared with family physicians or other providers upon the release of information signed by you.

I understand that I have the right to restrict how Jafferany Psychiatric Services uses or discloses my protected health information to carry out treatment, payment or health care operations; that Jafferany Psychiatric Services is not required to agree to the restrictions and; that Jafferany Psychiatric Services is bound by the restrictions to which it agrees.

I request the following restrictions to how my health information is used or disclosed:

_____

_____

_____

_____

I have the right to revoke this consent by notifying Jafferany Psychiatric Services in writing, except to the extent that Jafferany Psychiatric Services has already taken action in reliance on my consent.

_____ _____

Patient Signature Date

_____ _____

Parent/Guardian/Legal Representative Signature Date

_____ _____

Witness Signature Date

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TREATMENT RULES AND EXPECTATIONS

1. All intake forms are to be completed by the patient (or parent/guardian/ legal representative of the patient) before the Initial Appointment. It is the patient's responsibility to give accurate and complete information to aid the Provider in the assessment of needs.
2. The treatment plan for every patient assumes regular attendance at all sessions.
3. Two consecutive absences from scheduled appointments will be deemed as non-compliant and may result in termination from treatment.
4. Punctuality is expected for all appointments.
5. Patients that fail to show for an appointment or cancel with less than twenty-four hours notice will be charged a $100.00 fee that cannot be billed to insurance.
6. All patients have rights. We will maintain confidentiality and follow HIPAA Laws and CFR-42 Regulations. However, our Providers also have *duty-to-warn* legal obligations and may break confidentiality should any patient be a threat to him/herself or to someone else.
7. Any ongoing abuse of alcohol or drugs will greatly diminish the effectiveness of your treatment and is strongly discouraged. It may result in termination from treatment.
8. Any use, exchanging, supplying, receiving, or selling of controlled substances or alcohol at Jafferany Psychiatric Services is forbidden and will result in termination from treatment.
9. No guns, knives, or other weapons are allowed on the premises of Jafferany Psychiatric Services.

_____ _____

Patient Signature Date

_____ _____

Parent/Guardian/Legal Representative Signature Date

_____ _____

Witness Signature Date

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OFFICE POLICY STATEMENT

APPOINTMENTS

Providers are seen by appointment only. Reminder calls are made as a courtesy, it is ultimately your responsibility to keep track of your appointments as scheduled. Please be prompt to best use the time reserved for you. If you are more than five minutes late to your scheduled appointment, you will be required to reschedule, as we cannot extend sessions if you arrive late.

CANCELLATIONS AND NO-SHOWS

It is your responsibility to keep your appointment as scheduled. You may cancel or reschedule your appointment with at least a 24 hours advanced notice. Any cancellations without 24 hour prior notice, or any no shows, will be charged $100.00 for initial evaluations and $50.00 for medication management reviews. These fees will be added to your account and may not be billed to your insurance. Three no shows and/or late cancellations or two back-to-back no shows and/or late cancellations within a one year time frame will result in discharge from the practice.

PAYMENTS

Charges differ depending on the nature of the service delivered. Payment for the appointment fee and any ancillary charges are expected at the time of service, except for those with insurance coverage. We accept check, cash, credit cards, or debit cards. Any collection, legal fees, or costs necessary to collect unpaid balances will be your responsibility. Substantially overdue accounts will be sent to a collection agency after a warning letter.

FEES: Initial Psychiatric Evaluation, $283; subsequent Medication Reviews, $150 (with Insurance Companies paying their allowable amounts).

PAPERWORK

For paperwork you require completed, there is a fee of $10.00 per page. Disability paperwork will not be completed until you have been established as a patient for at least 6 months.

REFILLS

Please contact your pharmacy to initiate refill requests for any non-controlled medications. They will contact our office directly if they require further action. For any controlled medications, please contact our office. You may leave a message with the patient's name, date of birth, call back number, medication name, and pharmacy. Please allow up to 48 hours/two business days, for these to be processed. (Messages left Friday-Sunday may not be processed until Wednesday). It is the patient's responsibility to ensure that they do not run out of medication. A partial refill may be appropriate if your medication management appointment is less than a month away from your refill date.

PRIOR AUTHORIZATIONS

Prior authorizations are initiated when your prescription is denied at the pharmacy. The pharmacy will contact the office with a request to start the prior authorization process. We will fill out the corresponding form and send any and all necessary documents to your insurance company. They require 72 hours processing time. We will contact the patient once we receive a response from the insurance company.

MEDICATION CHANGES

All controlled medications will be maintained for 1 month, or until the current script expires, before any changes will be made.

MANDATORY RANDOM DRUG TESTING

As a result of new FDA standards, we will be requiring mandatory random drug testing. This change is effective immediately for all patients. Should you decline testing, you may be subject to dismissal from the practice.

GENETIC TESTING

Genetic testing is a painless process that shows how you metabolize certain types of medications. This allows the provider to see what medications will work the best for you. Should you wish to have genetic testing performed, please speak with your provider.

TELEPHONE ACCESS

For non-urgent matters, please call during business hours, Monday - Thursday from 7AM to 5PM. If you have an emergency and it is after business hours, please call 911 or go to the nearest hospital emergency room (ER). You may also leave a voicemail for us if you wish—

with your name, phone number and reason for calling. Although we will not receive it until the opening of the next business day, we will return your call as soon as possible.

CHANGES OF INSURANCE

If you have had a change of insurance since your last appointment, it would be in your best interest to contact our office prior to your next visit, as not all providers participate with the same insurances. As a result, you may be asked to reschedule with a provider who can accept your insurance. At the time of your appointment you must bring a copy of your insurance card and ID, so that we may update your file. If you fail to notify the front desk, or provide documentation of the insurance change, you will be responsible for the appointment fees as previously mentioned. This includes Medicaid patients.

I HAVE READ AND AGREE TO THE ABOVE.

Patient Signature	Date
Parent/Guardian/Legal Representative Signature	Date
Witness Signature	Date

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CONSENT TO RELEASE AND OBTAIN PROTECTED HEALTH INFORMATION

Patient Name: _____ DOB: _____

I authorize **JAFFERANY PSYCHIATRIC SERVICES** to disclose and/or obtain the Protected Health Information (PHI) that I have identified below with my initials.

Information Requested:

_____Entire Record	_____Medication	_____Therapy Assessment
_____Demographic Information	_____Participation in Treatment	_____Treatment Plan
_____Diagnosis	_____Progress in Treatment	_____Other_____
_____Discharge/Transfer Summary	_____Psychiatric Evaluation	

Dates of Treatment: _____

Method of disclosure (Please Circle One): Phone / Fax / Mail / Any

Purpose: The purpose of this disclosure of information is to improve assessment and treatment planning, to share information relevant to treatment and, when appropriate, to coordinate treatment services. (If it is for another purpose, please specify.)

_____

Expiration: I understand that this release will automatically expire one year from the date of my signature below unless I specify a different date, event or condition of expiration as follows: _____

Revocation: I understand that I have a right to revoke this authorization at any time by: 1) Sending written notification to Jafferany Psychiatric Services; 2) Giving verbal permission via telephone (Jafferany Psychiatric Services will ask for specific identifying information from me); 3) Making an in-person request and signing and dating a Revocation Form. I further understand that a revocation is not effective to the extent that action has already been taken in reliance upon this authorization.

Information is to be released to _____and/or obtained from _____the following individual(s) or organization: (Please **INITIAL** one or both)

Name _____
Address _____ City _____ State _____ Zip Code _____
Fax Number _____ Telephone Number _____

I understand that I am authorizing the release of information contained in my medical record which may include information about 1) Communicable diseases and infections such as Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS), and AIDS Related Complex (ARC); 2) Substance abuse treatment records protected under Federal regulations [42 CFR, Part 2]; and 3) Mental health treatment records, psychological/psychiatric services and social service information including communication made by me to a social worker, licensed professional counselor, psychologist, or psychiatrist, if any, to the individuals or organizations listed below.

I hereby release Jafferany Psychiatric Services and its staff from all legal responsibility that may arise from the release of the above information and/or these records. I understand that Jafferany Psychiatric Services may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form.

Patient Signature _____ Date _____
Parent/Guardian Signature _____ Date _____
Witness Signature _____ Date _____