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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ADULT INTAKE FORM

PATIENT INFORMATION

Name: _____
First Last
Date of Birth: _____ Age: _____ Gender_____ Race _____

Address: _____
Street City State Zip

Phone number(s): _____
Home Cell Work

E-mail address: _____

REFERRAL INFORMATION

Who referred you to this practice? Name: _____

Address: _____

Phone:_____ Fax:_____

PRESENTING PROBLEM

What is the **PROBLEM** for which you are seeking assistance? _____

When did you first notice this problem? _____

What caused you to seek treatment at this time?_____

How has this problem affected your **ABILITY TO FUNCTION**? At home: _____

At school/work: _____

In your community: _____

_____

What are the **LIFE STRESSORS** that contribute to this problem? _____

_____

_____

What are **SPECIFIC GOALS** you want to accomplish by being in treatment? How do you want your life to be different?_____

_____

_____

_____

SYMPTOM CHECKLISTS: Please indicate if you have experienced any of the following in the past two weeks. CIRCLE THE ITEM IF IT HAS BEEN LONG-STANDING OR SEEMS TO BE PART OF YOUR PERSONALITY.

DEPRESSION

- ☐ Sadness
- ☐ Hopeless/Discouraged
- ☐ Feelings of Failure
- ☐ Feeling Helpless
- ☐ Loss of Pleasure/Interest
- ☐ Feelings of Guilt
- ☐ Feeling Punished
- ☐ Loss of Confidence
- ☐ Self-criticism/Blame
- ☐ Hurting Yourself/Want to
- ☐ Suicidal Thoughts/wishes
- ☐ Crying
- ☐ Agitation / Restlessness
- ☐ Social Withdrawal
- ☐ Indecisiveness
- ☐ Feeling Worthless
- ☐ Loss of Energy/Fatigue
- ☐ Sleep Problems _____
- ☐ Irritability
- ☐ Appetite Change **+/-**
- ☐ Weight Gain/Loss __lbs.
- ☐ Concentration Difficulty
- ☐ Poor Memory
- ☐ Loss of Interest in Sex

BIPOLAR DISORDER

- ☐ Mood Swings
- ☐ Feeling "High" w/o drugs
- ☐ Elevated Self-Confidence
- ☐ More Outgoing/ Sociable
- ☐ Talking More or Faster
- ☐ Little Need for Sleep
- ☐ High Level of Energy
- ☐ Unusually Active
- ☐ Unusually Productive
- ☐ Can't Focus on Tasks
- ☐ Racing Thoughts
- ☐ Can't Shut Mind Off
- ☐ Irritable/Argumentative
- ☐ Jumpy/Can't Relax
- ☐ Excessive Spending
- ☐ Inapp. Sexual Behaviors
- ☐ Other Risky Behaviors

POSTTRAUMATIC STRESS DISORDER

- ☐ Traumatic Memories
- ☐ Distressed at Reminders
- ☐ Easily Startled / Aroused
- ☐ Avoids Reminders
- ☐ Frequent Nightmares
- ☐ Flashbacks
- ☐ Emotional Numbness
- ☐ Can't Remember Event

ANXIETY

- ☐ Constant Worrying
- ☐ Fear of the Worst
- ☐ Scared/Terrified
- ☐ Feeling Hot/Face Flushed
- ☐ Sweating w/o Heat
- ☐ Wobbliness in Legs
- ☐ Unsteady
- ☐ Hands Trembling
- ☐ Shaky
- ☐ Numbness/Tingling
- ☐ Nervous/Jittery
- ☐ Fear of Losing Control
- ☐ Fear of Going Crazy
- ☐ Fear of Dying
- ☐ Unable to Relax
- ☐ Muscle Tension
- ☐ Dizzy/Lightheaded/Faint
- ☐ Heart Pounding/Racing
- ☐ Feelings of Choking
- ☐ Difficulty Breathing
- ☐ Abdominal Discomfort

SOCIAL ANXIETY

- ☐ Shy/Timid
- ☐ Avoiding Crowds
- ☐ Avoiding Public Places
- ☐ Self-conscious
- ☐ Dislike Attention on You
- ☐ Feeling Judged by Others

OBSESSIVE COMPULSIVE DISORDER

- ☐ Obsessive Thoughts
- ☐ Repetitive Thoughts
- ☐ Compulsive Hand Washing
- ☐ Compulsive Counting
- ☐ Compulsive "Checking"
- ☐ Compulsive Neatness

ATTENTION/HYPERACTIVITY PROBLEMS

- ☐ Distractible
- ☐ Poor Concentration
- ☐ Many Unfinished Tasks
- ☐ Hyperactive
- ☐ Impulsive
- ☐ Procrastinates
- ☐ Forgetful
- ☐ Misplaces Things
- ☐ Indecisive
- ☐ Can't Sit Still
- ☐ Leaves Seat
- ☐ Interrupts Others

BEHAVIORAL PROBLEMS

- ☐ Physical Aggression
- ☐ Extreme Anger or Rage
- ☐ Verbal Altercations
- ☐ Destroying Property
- ☐ Throwing Things
- ☐ Fire Setting
- ☐ Hurting Animals

EATING DISORDERS

- ☐ Fear of Weight Gain
- ☐ Binging/Purging
- ☐ Distorted Body Image
- ☐ Excessive Exercising
- ☐ Excessive Dieting
- ☐ Excessive Overeating

DISSOCIATION

- ☐ Feeling Outside Your Body
- ☐ Things Feel "Not Real"
- ☐ Time Elapsed, No Memory
- ☐ Gaps in Knowledge

PSYCHOSIS

- ☐ Hearing Voices Others Don't
- ☐ Seeing Things Others Don't
- ☐ Paranoia
- ☐ Delusions

AUTISM SPECTRUM DISORDER

- ☐ Socially Unconnected/Awkward
- ☐ Avoids Eye Contact
- ☐ Language Impairments
- ☐ Rigidity/Inflexibility
- ☐ Unusual Repetitive Behaviors
- ☐ Intense Preoccupation with Subject

MENTAL HEALTH HISTORY

Have you recently experienced a **SIGNIFICANT LOSS?** _____ If yes, please explain:_____

_____

Have you ever been the **VICTIM OF ABUSE** (Physical, Emotional, Mental, Verbal or Sexual)? _____

Or the **VICTIM OF DOMESTIC VIOLENCE**? _____Or the **VICTIM OF NEGLECT** (Emotional or Physical)? _____If yes, please circle all that apply and explain (if you are comfortable doing so): _____

_____

_____

Have you ever been a **WITNESS OF VIOLENCE, ABUSE OR NEGLECT**? _____ If yes, please explain. _____

_____

_____

Have you ever been the **PERPETRATOR OF VIOLENCE, ABUSE OR NEGLECT**? _____ If yes, please explain. _____

_____

_____

Have you ever **HARMED YOURSELF INTENTIONALLY**? _____**ATTEMPTED SUICIDE**?_____ If yes, please explain. _____

_____

_____

MENTAL HEALTH DIAGNOSES: please REVIEW THE LIST BELOW and consider yourself, your immediate family, and all of your relatives on both sides of your family. (Maternal is your mother's side of the family and Paternal is your father's side of the family.) Include parents, brothers, sisters, aunts, uncles, grandparents, and first cousins.

IF YOU (OR A RELATIVE) HAVE BEEN DIAGNOSED WITH ANY OF THESE DISORDERS, CHECK THE APPROPRIATE BOX (ES). If a relative, describe his/her relation to you (such as maternal grandfather) and his/her treatment history (if applicable). *We ask for <u>your</u> treatment history elsewhere*.

You	Relative	
☐	☐	ADD/ADHD _____
☐	☐	Autism / Asperger's / Pervasive Developmental Disorder _____
☐	☐	Learning disabilities _____
☐	☐	Mental retardation/Intellectual Disability_____
☐	☐	Speech or Language Disorder _____
☐	☐	Alcohol/Drug Dependence/Abuse _____
☐	☐	Anger Problems/Intermittent Explosive Disorder_____
☐	☐	Anxiety (Chronic Worrying) _____
☐	☐	Body-Focused Repetitive Behaviors (Skin Picking, Hair Pulling)_____

You Relative

☐ ☐ OCD (Obsessive Compulsive Disorder) _____

☐ ☐ Panic Disorder _____

☐ ☐ Phobias _____

☐ ☐ Social Anxiety _____

☐ ☐ Depression/Dysthymia _____

☐ ☐ Bipolar Disorder (Manic Depression) _____

☐ ☐ PTSD (Post Traumatic Stress Disorder) _____

☐ ☐ Self harm/Self-mutilation _____

☐ ☐ Suicide, Attempted/Completed _____

☐ ☐ Eating Disorders _____

☐ ☐ Nervous breakdown _____

☐ ☐ Schizophrenia or Other Psychosis _____

☐ ☐ Seizures or Other Neurological Disorder _____

☐ ☐ Other _____

OUTPATIENT TREATMENT: Are you now receiving treatment, or have you received treatment in the past, for any of the problems above? _____If yes, please give information below:

Name Location When For how long? Problem/Diagnosis

Therapist: _____

_____

_____

Psychiatrist: _____

_____

_____

PSYCHIATRIC HOSPITALIZATION OR INTENSIVE DAY TREATMENT PROGRAM:

Where When (month/year) Type and Length of Stay Diagnosis Was it Productive?

_____

_____

_____

CURRENT PSYCHIATRIC MEDICATION:

Name Dosage When Prescribed Who Prescribed Response

_____

_____

_____

_____

_____

_____

Do you take your medication as prescribed? _____If not, please explain: _____

_____

PREVIOUS PSYCHIATRIC MEDICATION (if more than 12 medications, please attach a separate list):

Name	Highest Dosage	Duration of Use	Response	Reason for Stopping

SUBSTANCE USE:

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

INDIVIDUAL / GROUP SUBSTANCE ABUSE TREATMENT (AA, NA, etc.):

Year	Program	Was It Voluntary or Court Mandated?	Was It Productive?

SUPPORT GROUP ATTENDANCE for other issues (AL-ANON, ACOA, CoDA, OA, etc.)? _____
If yes, please explain: _____

SOCIAL HISTORY

PERSONAL MARITAL / RELATIONSHIP STATUS:

☐ Single ☐ Married ☐ Cohabiting ☐ Engaged ☐ Separated ☐ Divorced ☐ Re-married ☐ Widowed

Current Spouse or Partner (if applicable)_____Age_____

Years Married /Together _____ Describe your Relationship_____

Number of times Married?_____Divorced?_____Widowed? _____

Please List Previous Marriages / Long-term Relationships in order of occurrence (If applicable):

Name Number of Years Together Children? Reason for End

CHILDREN: Please list ALL Children (including step-children and children who do not live with you):

Name of Child Age Sex Live with you? Describe your relationship with him/her.

Please list all others who live/stay with you and their relation to you:_____

PARENTS: Please indicate the current marital/relationship status of your parents:

☐ Married ☐ Cohabiting ☐ Separated ☐ Divorced ☐ Re-married ☐ Widowed

Father's Name:_____Mother's Name:_____

How would you describe their relationship with each other when you were growing up?_____

If your parents are Divorced, how old were you at the time?_____

If one or both Re-married, how old were you at the time?_____

With whom did you live afterward?_____

Are your parents still living? _____ If not, please list which is deceased, the year, and the cause of death:

How would you describe your relationship with your mother when growing up?_____

Now (if applicable)?_____

How would you describe your relationship with your father when growing up?_____

Now (if applicable)?_____

SIBLINGS: Please list ALL siblings (If step or half, indicate the parents you have in common by M=Mother, F=Father, SM=Stepmother, SF=Stepfather; if deceased, write D by name and age died):
Name Age (Half or Step? Parents) Did they live with you? Describe your relationship.

EDUCATION: Highest Level of Education: _____ Did you receive Special Education Services in school? _____ If yes, please explain. _____

Are you currently enrolled in school? _____ If yes, where? _____
What is your Major/course of study? _____
When will you be finished? _____

MILITARY SERVICE: If no military history, check here: ☐

Branch: _____ Dates Served: _____

Discharge Rank: _____ Type of Discharge: _____

Did you sustain physical or psychological injuries in the Military? _____ If yes, please explain: _____

EMPLOYMENT: Please list your work history (beginning with your current/most recent job):
Employer Position Held Hrs/Wk Dates Reason Left

Are you Unemployed? _____ Seasonally? _____ Are you receiving Unemployment? _____

Are you on **SICK/MEDICAL LEAVE**? _____ **LONG TERM DISABILITY?** _____
WORKERS' COMPENSATION? _____ **SOCIAL SECURITY DISABILITY**? _____ **SSI**? _____
Are you awaiting resolution of a claim for any of the above? _____ If yes, please explain and give your Attorney's name (if applicable): _____

Have you had any **LEGAL PROBLEMS**, past or present? _____ If yes, please explain (dates/ offenses/incarcerations/current status): _____

Were you raised in a **RELIGION / FAITH / SPIRITUAL TRADITION**? _____ If yes, which one/ones? _____ Do you currently participate in a church or faith group? _____ If yes, where? _____
Is religion/faith/spirituality a meaningful part of your private life? _____ Please explain (if you are comfortable doing so): _____

Do you have an **ETHNIC HERITAGE** that is an influence on your life? _____ If yes, please explain:

What do you consider to be your **STRENGTHS** that will help you in treatment?_____

_____

_____

What **COPING SKILLS** have you used in the past? _____

_____

_____

Who would you say are the most **SUPPORTIVE PEOPLE** in your life? _____

_____

_____

Will anyone else be involved in your treatment?____If yes, who and to what extent?_____

_____

MEDICAL HISTORY

PRIMARY CARE PROVIDER: _____

Address: _____

Phone: _____Fax: _____

When was your last visit? _____ Last physical exam with bloodwork? _____

Are there other physicians/specialists you see on a regular basis? _____

_____

CHECK IF YOU HAVE EVER HAD:

☐ Loss of Consciousness ☐ Head Injury ☐ Seizures

CHECK IF YOU HAVE ANY OF THE FOLLOWING:

☐ AIDS/HIV
☐ Allergies
☐ Alzheimer's/Dementia
☐ Anemia/ Low Iron
☐ Arthritis
☐ Asthma
☐ Blood Disorder
☐ Chronic Back or Neck Pain
☐ Chronic Fatigue Syndrome
☐ Chronic Nosebleeds
☐ COPD/Emphysema
☐ Diabetes
☐ Fibromyalgia
☐ GERD (Acid Reflux)/Ulcers
☐ Hearing Problems
☐ Heart Attack/Heart Disease
☐ High Blood Pressure
☐ High Cholesterol
☐ IBS/Crohn's Disease/Celiac Disease
☐ Kidney Disease
☐ Liver disease
☐ Menstrual Problems
☐ Migraine Headaches
☐ Multiple Sclerosis
☐ Obesity
☐ Paralysis/ Loss of Sensation
☐ Parkinson Disease
☐ Prostate Problems
☐ Skin Conditions/Eczema/Dermatitis
☐ Stroke/ TIA
☐ Thyroid problems
☐ Vision

☐ Cancer
If yes for cancer, what type and what treatment (if applicable)? _____

☐ Surgeries
If yes for surgeries, what type? _____

Do you have any other medical problems not listed above? If so, please list here: _____

CURRENT NON-PSYCHIATRIC MEDICATIONS: (if more than 6, please attach a separate list)

Name	Dosage	Duration	Response

Do you take these medications as prescribed? _____ If not, please explain: _____

DRUG ALLERGIES AND REACTIONS: _____

Signature:_____ **Date:** _____

If someone other than the patient completed or helped complete this form:

Signature:_____ **Date:** _____

(*Please Circle*: Spouse/Guardian/Legal Representative/Other_____)

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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 _____