New Patient Information

Name (Last)_____(First)_____(M.I.)_____

Address_____City_____State_____Zip_____

Marital Status_____ Sex: M F Employer_____

Birth Date_____Age_____ Social Security Number _____

Home Phone (___) _____Work (___) _____Cell (___)_____

Closest Relative not living with you _____ Phone (___)_____

Address_____ City_____State_____Zip_____

Person Responsible for Payment (complete only if different from above)

Name_____ Relationship_____ Employer_____

Home Phone (___) _____Work Phone (___)_____

Insurance Information

Name of Primary Insurance_____

Contract #_____ Group #_____Effective Date_____

Request for Confidential Handling of Health Information

Complete only if you want communications regarding your health care information sent to an alternate address or telephone other than listed above. I request that my provider handle my confidential health information as described below. All reasonable requests to receive communication of your health information by alternative means and/or locations will be granted. Please describe the alternative means below (e.g. US mail, telephone call, etc.) by which you prefer to receive your health information.

Alternate Address_____

Alternate Telephone_____ Alternate Telephone_____

Agreement

If your insurance company OR health plan requires pre-approval OR referral for your visit, it is your responsibility to obtain this referral or YOU will be personally responsible for the bill. I, the undersigned (patient or legal guardian), authorize medical treatment to be rendered by the provider and assume financial responsibility. In the event the account is not paid in full within 90 days*, the undersigned agrees to pay all costs of collection including reasonable attorney fees, and hereby waives all rights of exemption under the constitution and laws of the State of Alabama. I also authorize the release of my medical records to my physicians and insurance carriers. If the provider has a contractual arrangement with your insurance carrier, the balance refers only to the amount that you are required to pay. I understand that all of the providers in the offices at 2018 Brookwood Medical Center Drive, POB Suite 311 and POB Suite 310 are independent practitioners (not partners) although they are sharing office and staff. Your signature below also indicates you have received the Alabama Notice Form: Notice of Policies and Practices to Protect the Privacy of your Health Information and agree to its terms and serves as an acknowledgement that you have been given a copy of the HIPAA Notice Form.

Signature of Patient or Responsible Party_____Date_____

If signed by a responsible party, describe that representative's authority to act for the patient_____

Rich ..Azrin, Ph. D. • Cheryl Millsaps A.. ..h. D.
Margaret Smith, LCSW • Jeannie Briscoe, LCSW
2018 Brookwood Medical Center Drive
Professional Office Building, Suite # 310 Birmingham AL, 35209
Voice: (205) 329-7815 • Fax (205) 329-7816

Patient Name: _____ Date of Birth: _____

Social Sec. # _____ Date(s) of requested records: _____

I hereby authorize the above providers to obtain and release the protected information specified below.
Please list any restrictions on this release of information _____

Name _____ Phone _____ Fax _____
Address _____
City State Zip

Name _____ Phone _____ Fax _____
Address _____
City State Zip

Name _____ Phone _____ Fax _____
Address _____
City State Zip

Name _____ Phone _____ Fax _____
Address _____
City State Zip

Name _____ Phone _____ Fax _____
Address _____
City State Zip

Records to be Obtained: Please send copies of all EEG, MRI, CT, History and Physical, and the doctors last progress notes.
Release: This form when completed and signed by you, authorizes me to release, as well as obtain, protected information from your clinical record to and from the person(s) you designate. I hereby authorize Dr. Richard Azrin, Dr. Cheryl Millsaps, Margaret Smith, LCSW, Dr. Stuart Tieszen, Dr. Elena Herndon, Dr Joel Melvin, Jeannie Briscoe, LCSW and/or his or her administrative and clinical staff to release any and all contents of my chart (including at least billing information, psychotherapy/progress notes, test results/data, reports, visit information, prescriptions, medical information, documents provided by patient, insurance/third party forms/reports, records received by others). This information should only be released to and/or obtained from the above individuals. I am requesting my psychologist, psychiatrist, or social worker release this information to aid in treatment and/or assessment and/or provide information about me to others. This authorization shall remain in effect indefinitely. However, you have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that my psychologist, psychiatrist, or social worker generally may not condition psychological services upon my signing an authorization unless the services are provided to me for the purpose of creating health information for a third party. I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.
I hereby release the above treatment/assessment providers and their respective medical staff and office from any and all liability and claims arising out of or relating to the disclosure and/or release of confidential and/or privileged information.
Informed Consent: I agree to participate in evaluation/treatment, and the purpose has been explained to me and/or my guardian/representative.

Name of patient and/or responsible party _____ Signature of patient or responsible party _____ Date _____

If signed by patient's representative, a description of representative's authority to act for the patient is provided above.

***** Please fax records to Fax# (205) 329-7816 OR call Voice # (205) 329-7815**

Policy for Canceling and Rescheduling Appointments

It is the policy of Jeannie Briscoe's office to charge a fee of $80.00 for any appointment that is missed or broken without at least one business day notice. The payment is due prior to rescheduling your next appointment.

We make every effort to remind you of scheduled appointments. When an appointment is scheduled in our office, we provide you with the doctor's business card with the appointment time and date indicated. We also attempt to make courtesy reminder calls one business day before your appointment. Please be advised, however, that it is ultimately your responsibility to keep track of your appointments.

We appreciate your understanding of this policy. Please feel free to speak to our office staff if you have any questions.

I have read the above policy and agree to abide by the terms indicated when scheduling appointments.

Patient Signature: _____ Date: _____

Insurance Confirmation

Patient Name:_____ See other insurance confirmation for secondary:____

Insurance ID#:_____ Social Sec #:_____

Insurance Company:_____ DOB:_____

Date of Call:_____ Time:_____ Person from insurance company spoke to:_____

Send Claims to:_____

If Blue Cross of Alabama: Is there an EPS____ or EPX____ rider

Policy Effective Date:_____ Is this policy: Primary____ or Secondary____

Is there a waiting period for preexisting conditions? If Yes, how long?_____ No____

What is the Mental Health Coverage for psychological or neuropsychological testing (96100 or 96117)

% of UCR____ or Copay $____ / Deductible amount $____ How much of Deductible Met: ALL or $____

Psycho therapy: Number of visits allowed annually:_____ Number used so far:____

If needed, What are the out of network benefits?_____

Medical Coverage:
% of UCR____ or Copay $____ / Deductible amount $____ How much of Deductible Met: ALL or $____

Notes:_____

Referral
Is there a Referral required for psych (96100) or neuropsych (96117) testing? (medical or mental)

No____ If Yes, from which doctor_____ Phone:_____

Referral obtained: (number or who called/date):_____

Is precertification needed for 96117 (neuropsych testing)_____ or , if insurance won't allow 96117 then check 96100 (psychological testing)_____ and 90801 (diagnostic interview)_____

- Inpatients: Precert UBH, Magellan, Medicare Complete
- C:\My Documents\Insurance billing\Insurance Confirmation form.doc

Alabama Notice Form: Notice of Policies and Practices to Protect the Privacy of Your Health Information (NPP)

This notice describes how psychological, psychiatric, and medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

I. Uses and Disclosures for Treatment, Payment and Health Care Operations

I may use or disclose your protected health information (PHI), for treatment, payment and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

- "PHI" refers to information in your health record that could identify you.
- "Treatment, Payment and Health Care Operations"
    - Treatment is when I provide, coordinate or manage your health care and other services related to your health case. An example of treatment would be when I consult with another health care provider, such as your family physician or another health care provider.
    - Payment is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
    - Health Care Operations are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "Use" applies only to activities within my [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "Disclosure" applies to activities outside of my [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment or health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing you Psychotherapy Notes. "Psychotherapy Notes" are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have previously relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- Child abuse-If I am treating a child and I know or suspect that child to be a victim of child abuse or neglect, I am required to report the abuse or neglect to a duly constituted authority.
- Adult and Domestic Abuse-If I have reasonable cause to believe an adult, who is unable to take care of himself or herself, has been subjected to physical abuse, neglect, exploitation, sexual abuse, or emotional abuse, I must report this belief to the appropriate authorities.
- Health Oversight Activities-If my professional state board of examiners is conducting an inquiry into my practice, then I am required to disclose PHI upon receipt of a subpoena from the Board.
- Judicial and Administrative Proceedings-If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information may be privileged under state law, and I will not release information without the written authorization of you or your legally appointed representative or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- Serious Threat to Health or Safety-I may disclose PHI to the appropriate individuals if I believe in good faith that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of you or another identifiable person(s).
- Health Research
- Worker's Compensation-I may disclose PHI as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault

PATIENT QUESTIONNAIRE

Full name _____ Date: _____

☐ Male; ☐ Female Birthdate _____ Marital status _____ Age _____ Race _____

Address _____ Phone _____

Occupation _____ Phone _____

Other significant contact _____ Phone _____

Referred by _____

CLINICAL HISTORY

List problems for which evaluation is sought:

		Length of time
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____

Impairment associated with current problems:

	Not at all	A little bit	Moderately	Quite a bit	Extremely
Work					
Social life					
Daily activities					

What have you tried so far to correct these problems (changes in life, psychotherapy, drugs) ?

_____

_____

What specific event(s) caused you to seek help at this time ? _____

_____

List **all clinicians** that have evaluated or treated you. ☐ None

Clinician	Reason	Type of treatment	Year and length
1.			
2.			
3.			
4.			

List **prescribed and non-prescribed medications** you are presently taking: ☐ None

Medication	Reason	Dosage	Length of treatment
1.			
2.			
3.			
4.			
5.			

CURRENT PERSONAL CIRCUMSTANCES

Spouse's name _____ Years together _____

Age _____ Education _____ Occupation _____

General relationship with spouse _____

Physical or emotional problems _____

List all persons living in the household with you:

Name	Age	Relationship	Education	Occupation
1.				
2.				
3.				
4.				
5.				

Please check all events that may have occurred within the past 12 months:

☐ Significant marital conflicts
☐ Separation
☐ Divorce
☐ Spouse with emotional difficulties
☐ Death of spouse
☐ Marriage
☐ Pregnancy
☐ Birth of child
☐ Gain of new family member
☐ Child leaving home

☐ Death of close family member
☐ Death of close friend
☐ Personal injury or illness
☐ Change in financial status
☐ Change in residence

☐ Significant conflicts at work
☐ Losing job
☐ Change in job
☐ Legal problems
☐ Other stress _____

Leisure and recreational activities _____
Religious affiliation and practice _____
Any legal problems ? ☐ No ☐ Yes. Explain _____

FAMILY HISTORY

Mother's full name _____
Age _____ Education _____ Occupation _____
General relationship with mother _____
Health problems or cause of death _____

Father's full name _____
Age _____ Education _____ Occupation _____
General relationship with father _____
Health problems or cause of death _____

Brothers and sisters:

Name	Age	Education	Occupation	Relationship
1.				
2.				
3.				
4.				

Check if any natural parent, brother, sister, uncle, aunt, cousin or grandparent has:

☐ Attention deficit/hyperactivity disorder
☐ Learning disabilities
☐ Mental retardation
☐ "Blues", depressions
☐ Attempted suicide
☐ Bipolar/Manic depressive illness
☐ Problems with anxiety or panic attacks
☐ Problems with alcohol or drugs
☐ Schizophrenia
☐ Other psychiatric problem
☐ Tics, seizures or neurologic problem
☐ Legal problems

Please describe and indicate relation _____

DEVELOPMENTAL AND SOCIAL HISTORY

Were there any problems with your mother's pregnancy or delivery of you ? ☐ No ☐ Yes
Explain _____

Were you born full term ? ☐ Yes ☐ No. Mother's age when you were born _____

Did you experience any separations from your parents as a child ? ☐ No ☐ Yes. Explain _____

What were you like as a child ?

☐ Affectionate	☐ Very sensitive	☐ Irritable	☐ Moody
☐ Content	☐ Distractible	☐ Overly active	☐ Aggressive
☐ Fearful	☐ Playful	☐ Fussy / cranky	☐ Shy
☐ Physically sick	☐ Quiet	☐ Nervous	☐ Obedient

Did you ever experienced verbal / physical abuse ? ☐ No ☐ Yes. Explain _____

Did you ever experienced sexual abuse ? ☐ No ☐ Yes. Explain _____

What were you like during adolescence ?

☐ Confident	☐ Shy	☐ Overly active	☐ Happy
☐ Sociable	☐ Aggressive	☐ Forgetful	☐ Defiant
☐ Irritable	☐ Peaceful	☐ Explosive	☐ Responsible
☐ Rebellious	☐ Depressed	☐ Unconventional	☐ Moody

List some good things about you. What can you do well ? Any special talents ? _____

Have you been married more than once ? ☐ No ☐ Yes. Explain. _____

List all children residing away from home or deceased:

Name	Age	Education	Occupation	Relationship
1.				
2.				
3.				
4.				

MEDICAL HISTORY AND HABITS

Your physician or family doctor _____ Phone _____

Are you allergic to medication or anything ? ☐ No ☐ Yes. Explain _____

_____

List all physical problems presently under treatment or observation: Length of time

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____
5. _____ _____

Do you have or had any of the following ?

☐ Eye problems
☐ Hearing problems
☐ Speech problems
☐ Severe headaches
☐ Staring spells
☐ Seizures
☐ Motor/vocal tics
☐ Heart trouble
☐ Head trauma
☐ Asthma
☐ Liver disease
☐ Kidney problems
☐ Other medical problem. Explain _____

Have you ever been hospitalized ? ☐ No ☐ Yes. Explain _____

_____

List surgical operations or injuries: Date occurred Any complications?

1. _____ _____ _____
2. _____ _____ _____
3. _____ _____ _____
4. _____ _____ _____

Do you have or had any difficulty with drugs/alcohol? ☐ No ☐ Yes. Explain _____

How much alcohol do you drink on average per week ? _____

How much coffee or tea do you drink on average per day ? _____

How many cigarettes do you smoke per day? _____ How many years ? _____

Only for females:

Date of first menstrual period _____ Date of last menstrual period _____

Are the menstrual periods regular ? ☐ Yes ☐ No. Explain _____

_____

Are you on birth control ? ☐ Yes ☐ No. Explain _____

List of pregnancies and age _____

List of miscarriages/ abortions and age _____

Problems with pregnancies or deliveries ? ☐ Yes ☐ No. Explain _____

EDUCATIONAL AND WORK HISTORY

Educational degree and year completed _____

Describe your school performance:

Grade level	Academics	Conduct
Elementary School		
Middle School		
High School		
College		

Did you pass each grade/year ? ☐ Yes ☐ No. Explain _____

Were you ever enrolled in special services for

☐ Reading problems ☐ Speech and language disorder

☐ Mathematics problems ☐ Emotional/Behavioral problems

How did you get along with peers and teachers ? _____

_____

Past occupational and military history:

Employer	Type of job / position	Years of service