PATIENT INFORMATION/REGISTRATION FORM

Name: _____
Last Name First Name Middle I.

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work/Cell: _____

DOB: _____ Age: _____ SSN: _____

Sex (M/F): _____

Marital Status (Single/Married/Divorced/Widowed/Other): _____

Emergency Contact: _____ Relationship _____

Emergency Contact Phone: _____ Work/Cell: _____

Past Mental Health Treatment (Y/N): ___ If yes, where: _____

Who referred you: _____

Current Medications: _____

Allergies: _____

Pharmacy: Local: _____ Mail Order: _____

Today's Date: _____

MEDICAL HISTORY

ALLERGIES: _____ NO ALLERGIES: _____

Medical conditions that you currently (or in the past) have received treatment for (including surgeries):

_____

_____

_____

_____

Current medications (include all medications for any condition):

Medication Name	Dose	Frequency

Past psychotropic medications that you have been prescribed:

Primary Care Provider and other treating Physicians or Therapists:

Name	Type of Provider	Phone
		++

***Psychiatric Hospitalizations Have you ever been Psychiatrically Hospitalized? YES / NO**

If yes, Location(s) and Date(s): _____

_____ _____

_____

*** Substance Abuse Are you currently, or have you in the past, abused nicotine?**

_____

***Are you currently or have you in the past used, abused, or been dependent on opiates (including pain medications), marijuana, cocaine, or other drugs of abuse?**

_____

_____

_____

Do you drink alcohol? If so, type, amount, and frequency:

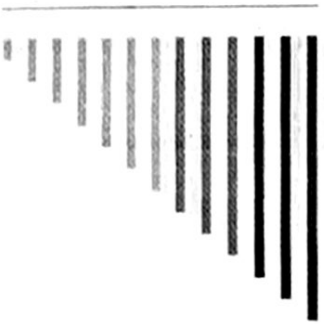
_____

_____

***This form has been completed to the best of my knowledge and ability.**

_____ _____

PATIENT SIGNATURE DATE



Alamir Health Inc.

28871 Center Ridge Rd #101
Westlake, Ohio 44145

Phone: 440-250-2130
Fax: 440-250-2140
E-mail: alamirhealth@yahoo.com

PRACTICE POLICIES

Appointments:

_The office will always try to see you at your appointed time. If you arrive late, you may not be seen.

– At the end of each appointment, you will be given a date and time for your next appointment, or arrangements will be agreed upon for how follow-up will be arranged.

– If you need to cancel or reschedule your appointment, you need to notify the office at least 24 hours before your appointment time.

– If you do not cancel/reschedule your appointment with 24-hour notice, you may be charged $25.00. If so, the office will notify you and payment may need to be received before you are rescheduled.

– If the office reschedules or cancels your appointment, you will not be charged a fee.

– If you do not show up for a scheduled appointment, or if you reschedule/cancel with a frequency that is deemed disruptive to your medical care and/or office practice, you may be terminated from the practice.

– In case of an emergency the patient should call 911 and/or go to the nearest ER.

Prescription Policies (if applicable):

– At your appointment, you will be given prescription(s) to last you until the next appointment. – It is the patients' responsibility to make sure that the office has the correct pharmacy information.

– Refill requests will be submitted to the pharmacy within 48 hours of the request; not counting weekends or holidays.

Controlled Substance Prescriptions (if applicable):

– Patient is expected to take medication as prescribed and/or agreed upon. If you take more than prescribed, or for any other reason run out early, you may be denied refills.

– If your controlled substance is lost or stolen, a copy of a submitted police report may be required prior to considering a refill.

– Refills of controlled substances are only given at appointments. Your Physician can decide to not refill controlled substances without an appointment.

– If you are using illicit drugs, abuse alcohol, or abuse/misuse prescribed medications, you may not be prescribed controlled substances.

– You may be asked to submit a drug screen at any point during your treatment. – Bring in your prescribed controlled substance(s) to all appointments. You may be asked for a pill count.

Termination:

– If your provider feels that the Physician-Patient relationship is not conducive to continued care, the patient may be terminated from services.

– If patient does not abide by this agreement, services may be terminated.

– The patient has the option to not sign this form. Not signing this form will lead to treatment relationship not being established or termination of services.

– In the event of termination of services, patient will be provided with alternative treatment resources.

I acknowledge that I have read, understand, and agree to follow the outlined policies and procedures.

_____ _____ _____

Patient Signature Printed Name Date

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PRIVACY CONSENT FORM

This consent is required by the Health Insurance Portability and Accountability Act of 1996 to inform you of your rights for privacy with respect to your health care information.

I hereby give my consent to ALAMIR HEALTH INC. to use and disclose my protected health information for the purpose of treatment, payment and operations of my health care and this practice.

Consent for treatment: I, with my signature, authorize ALAMIR HEALTH INC. and any employee working under the direction of the physician, to provide medical care for me, or to this patient for which I am legal guardian. This medical care may include services and supplies related to my health (or the identified person) and may include (but limited to) preventive, diagnostic, therapeutic, rehabilitative, maintenance, palliative care, counseling, assessment or review of physical or mental status/function of the body and the sale or dispensing of drugs, devices, equipment or other items required and in accordance with a prescription. This consent includes contact and discussion with other health care professionals for care and treatment.

Consent for release of information for payment and operations: I also authorize this practice to furnish information to the identified insurance carrier(s) for any and all payment activities. I acknowledge that my provider may use an electronic medical record and transmit information electronically. I further consent to the use for any practice operational needs as identified in the practice privacy notice.

Consent related to the Privacy Notice: I have had a chance to review the Practice Privacy Notice as part of the registration process. I understand that the terms of the Privacy Notice may change, and I may obtain these revised notices by contacting the practice by phone or in writing. I understand I have the right to request how my Protected Health Information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed, but the practice is not required to agree to my restrictions. If it does agree to my restrictions on PHI use, it is bound by that agreement.

I understand that ALAMIR HEALTH INC.may refuse me services if I refuse to sign this consent. I may revoke this consent at any time, but the practice may refuse further services. Revoking the consent must be done in writing. If I revoke this consent, the revocation does not take effect until the practice receives the written revocation.

Consent for assignment of benefits: I consent to assign all payments for these services to ALAMIR HEALTH INC. understand that I am responsible for all co-payments, amounts applied to deductibles and other amounts that may be deemed my responsibility by the payment sources, as required by my contracts with my insurance plan and state regulation. I further understand that my contract with my insurance entity may or may not cover some services.

It is my responsibility to obtain information from my health plan about service coverage. If I seek care outside of the contract, I am aware that I may be responsible for all charges that are incurred.

PATIENT/GUARDIAN SIGNATURE NAME PRINTED DATE

Revocation:

I hereby revoke the consent given above:

PATIENT/GUARDIAN SIGNATURE DATE

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PAYMENT POLICIES

Thank you for choosing us as your care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have decided to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance: We participate in most insurance plans. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-Payments and deductibles: All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. Non-covered services: Please be aware that some -perhaps all- of these services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. Proof of insurance: All patients must complete our patient information form before seeing your provider. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. Claim submissions: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. Coverage changes: If your insurance changes please notify us before your next visit so we can make the appropriate changes to help receive your maximum benefits.

7. Non-payment: If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30-days to find alternative medical care. During that 30-day period, our providers will only be able to treat you on an emergency basis.

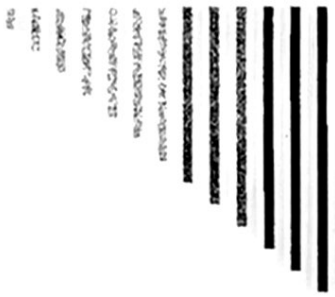
8. Missed appointments: Our policy is to charge for missed appointments not canceled at least 24 hours prior to your appointment. These charges will be your responsibility and billed directly to you. We currently charge $25 for any no-show or cancellations that occur less than 24 hours prior to your appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Patient/Guardian Signature Date



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RELEASE OF INFORMATION AUTHORIZATION

By signing this form, I hereby authorize Alamir Health Inc. to:

_____Obtain individual health records

_____Release individual health care records

From/To: Name/Facility: _____

Phone/Fax: _____

Address: _____

I understand that this authorization extends to all or any part of the records/information designated below. This may include treatment for physical and mental illness, alcohol/drug abuse, HIV/AIDS test results or diagnoses. The information released can be verbal or written and includes:

____ Medical Records ____ Treatment Plan ____ Psychiatric Evaluation ____ Progress Notes

____ Consultation Report ____ Medication Records _____FMLA/Disability Paperwork

The purpose of releasing this information is:

____ Continued Medical Treatment ____ Other: _____

I hereby release Alamir Health Inc., and the above-mentioned disclosing/receiving entity from all legal responsibilities or liability that may arise from the use or disclosure of medical records and/or other information.

Expiration: Valid indefinitely unless revoked or according to relevant state law.

Revocation: I understand I have the right to revoke this consent at any time in writing or verbally followed by in writing. Revocation takes effect at the date/time it is received and does not encompass information already released.

Refusal: I have the right to refuse to sign this form. Doing so may terminate treatment relationship.

_____	_____	_____	_____
Patient/Guardian Signature	Date	Printed Name	Date of Birth

PATIENT HEALTH QUESTIONNAIRE (PHQ)

This questionnaire is an important part of providing you with the best health care possible. Your answers will help in understanding problems that you may have. Please answer every question to the best of your ability unless you are requested to skip over a question.

Name_____ Age_____ Sex: ☐ Female ☐ Male Today's Date_____

1. During the last 4 weeks, how much have you been bothered by any of the following problems?	Not bothered	Bothered a little	Bothered a lot
a. Stomach pain	☐	☐	☐
b. Back pain	☐	☐	☐
c. Pain in your arms, legs, or joints (knees, hips, etc.)	☐	☐	☐
d. Menstrual cramps or other problems with your periods	☐	☐	☐
e. Pain or problems during sexual intercourse	☐	☐	☐
f. Headaches	☐	☐	☐
g. Chest pain	☐	☐	☐
h. Dizziness	☐	☐	☐
i. Fainting spells	☐	☐	☐
j. Feeling your heart pound or race	☐	☐	☐
k. Shortness of breath	☐	☐	☐
l. Constipation, loose bowels, or diarrhea	☐	☐	☐
m. Nausea, gas, or indigestion	☐	☐	☐

2. Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
a. Little interest or pleasure in doing things	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless	☐	☐	☐	☐
c. Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
d. Feeling tired or having little energy	☐	☐	☐	☐
e. Poor appetite or overeating	☐	☐	☐	☐
f. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
h. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐

FOR OFFICE CODING: Som Dis if at least 3 of #1a-m are "a lot" and lack an adequate biol explanation.
Maj Dep Syn if answers to #2a or b and five or more of #2a-i are at least "More than half the days" (count #2i if present at all).
Other Dep Syn if #2a or b and two, three, or four of #2a-i are at least "More than half the days" (count #2i if present at all).

3. Questions about anxiety.		NO	YES
a.	In the last 4 weeks, have you had an anxiety attack — suddenly feeling fear or panic?	☐	☐
If you checked "NO", go to question #5.			
b.	Has this ever happened before?	☐	☐
c.	Do some of these attacks come suddenly out of the blue — that is, in situations where you don't expect to be nervous or uncomfortable?	☐	☐
d.	Do these attacks bother you a lot or are you worried about having another attack?	☐	☐

4. Think about your last bad anxiety attack.		NO	YES
a.	Were you short of breath?	☐	☐
b.	Did your heart race, pound, or skip?	☐	☐
c.	Did you have chest pain or pressure?	☐	☐
d.	Did you sweat?	☐	☐
e.	Did you feel as if you were choking?	☐	☐
f.	Did you have hot flashes or chills?	☐	☐
g.	Did you have nausea or an upset stomach, or the feeling that you were going to have diarrhea?	☐	☐
h.	Did you feel dizzy, unsteady, or faint?	☐	☐
i.	Did you have tingling or numbness in parts of your body?...	☐	☐
j.	Did you tremble or shake?	☐	☐
k.	Were you afraid you were dying?	☐	☐

5. Over the <u>last 4 weeks</u>, how often have you been bothered by any of the following problems?		Not at all	Several days	More than half the days
a.	Feeling nervous, anxious, on edge, or worrying a lot about different things.	☐	☐	☐
If you checked "Not at all", go to question #6.				
b.	Feeling restless so that it is hard to sit still.	☐	☐	☐
c.	Getting tired very easily.	☐	☐	☐
d.	Muscle tension, aches, or soreness.	☐	☐	☐
e.	Trouble falling asleep or staying asleep.	☐	☐	☐
f.	Trouble concentrating on things, such as reading a book or watching TV.	☐	☐	☐
g.	Becoming easily annoyed or irritable.	☐	☐	☐

FOR OFFICE CODING: Pan Syn if all of #3a-d are 'YES' and four or more of #4a-k are 'YES'. Other Anx Syn if #5a and answers to three or more of #5b-g are "More than half the days".

	NO	YES
6. Questions about eating.		
a. Do you often feel that you can't control what or how much you eat?	☐	☐
b. Do you often eat, within any 2-hour period, what most people would regard as an unusually large amount of food?	☐	☐
If you checked "NO" to either #a or #b, go to question #9.		
c. Has this been as often, on average, as twice a week for the last 3 months?	☐	☐

7. In the last 3 months have you often done any of the following in order to avoid gaining weight?	NO	YES
a. Made yourself vomit?	☐	☐
b. Took more than twice the recommended dose of laxatives?	☐	☐
c. Fasted — not eaten anything at all for at least 24 hours?	☐	☐
d. Exercised for more than an hour specifically to avoid gaining weight after binge eating?	☐	☐

	NO	YES
8. If you checked "YES" to any of these ways of avoiding gaining weight, were any as often, on average, as twice a week?	☐	☐

	NO	YES
9. Do you ever drink alcohol (including beer or wine)?	☐	☐
If you checked "NO" go to question #11.		

10. Have any of the following happened to you more than once in the last 6 months?	NO	YES
a. You drank alcohol even though a doctor suggested that you stop drinking because of a problem with your health.	☐	☐
b. You drank alcohol, were high from alcohol, or hung over while you were working, going to school, or taking care of children or other responsibilities.	☐	☐
c. You missed or were late for work, school, or other activities because you were drinking or hung over.	☐	☐
d. You had a problem getting along with other people while you were drinking.	☐	☐
e. You drove a car after having several drinks or after drinking too much.	☐	☐

11. If you checked off any problems on this questionnaire, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

FOR OFFICE CODING: Bul Ner if #6a,b, and-c and #8 are all 'YES'; Bin Eat Dis the same but #8 either 'NO' or left blank.
Alc Abu if any of #10a-e is 'YES'.