American Psychiatric Care

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Please read all the information below and complete every step before sending in the paperwork

1) Send a copy of a state issued ID or Drivers License
(If the appointment is for a child, then send a copy of a parent's ID or guardian's ID)

2.) **Send a copy of the front and back of your insurance card(s)**

(Either take a picture then send it through email to: support@americanpsychcare.com

Or

Fax it to our office at 443-372-5365)

Please make sure to complete the documents in their entirety, otherwise an appointment will not be scheduled. If you are scheduling an appointment for a child under the age of 18, you must fill out the Consent to Treat a Minor document on the last page.

If you have any questions, please call the office at 410-670-3076 option 1

2014 South Tollgate Road, Suite 208, Bel Air, Maryland 21015
Telephone: 410-670-3076 Fax: 443-372-5365
www.americanpsychcare.com

PATIENT DATA INTAKE
American Psychiatric Care L.L.C.
Phone: 410-670-3076 Fax: 443-372-5365
www.americanpsychcare.com

Date: _____ Referred By: _____

Please fill out this form completely, circle the answer when necessary, and sign where indicated

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone: Home _____ Work _____ Cell _____

SSN: _____ Birth Date: _____ Current Age: _____ Sex: _____

Our electronic health records will send reminders to your email address or by text to your cell phone. I give my consent to receive reminders and messages to the following:

Email Address: _____ Cell Phone: _____

Signature: _____

Ethnicity: Hispanic, Latina/ Spanish origin? Yes or No Race: _____

Do you speak a language other than English at home? Yes or No

If yes, what language? Spanish Other _____

INSURANCE INFORMATION: *(Please provide us with a copy of all insurance cards)*

Primary Insurance Plan: _____ Policy No: _____ Group No: _____

Policy Holder Name and Address: _____

Employer/ Address: _____

Phone: Home: _____ Work: _____ Cell: _____

Secondary Insurance Plan: _____ Policy No: _____ Group No: _____

Holder Name and Address: _____

Employer/ Address: _____

Phone: Home: _____ Work: _____ Cell: _____

EMERGENCY CONTACT: Relationship: _____ Name: _____

Address: _____

Phone: Home: _____ Work: _____ Cell: _____

MEDICAL INFORMATION:

Current Medications: _____

_____

Past Medications: _____

_____

Have you ever had a history of substance abuse? Yes or No

If yes, please briefly explain: _____

Primary Care Physician: _____ Phone: _____ Fax: _____

Address: _____

Pharmacy: _____ Phone: _____ Fax: _____

Address: _____

American Psychiatric Care

Patient: _____

Date: _____

Current Medications:

MEDICATION	DOSAGE	FREQUENCY

Allergies: _____ _____

Surgeries: _____ _____

Psychological History: Mother _____ Siblings _____

Father _____ Grandparents _____

Suicide / Attempts: yes no **Relationship:** _____

Please Circle:

Smoker: yes no former how many _____

Alcohol: yes no former how much _____ how often _____ rehab? yes no

Heroine: yes no former how much _____ how often _____ rehab? yes no

Cocaine: yes no former how much _____ how often _____ rehab? yes no

Cannibis: yes no former how much _____ how often _____ rehab? yes no

Other: yes no former how much _____ how often _____ rehab? yes no

(Molley, LSD, Pain Medication, Mushrooms)

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AMERICAN PSYCHIATRIC CARE

PAST MEDICATION HISTORY

NAME: _____ DOB: _____ _ DATE: _____

Please Mark (x) in the box next to any PAST MEDICATIONS you have taken:

X	ANTIDEPRESSANTS	X	ANTIPSYCHOTICS	X	PAIN
	Celexa/citalopram		Abilify/aripiprazole		Methadone
	Lexapro/escitalopram		Saphris/asenapine		Dilaudid/hydromorphone
	Prozac/fluoxetine		Latuda/lurasidone		MS Contin
	Luvox/fluvoxamine		Zyprexa/olanzapine		Oxycontin/oxycodone
	Paxil/paroxetine		Invega/paliperidone		Tylenol-codeine
	Zoloft/sertraline		Seroquel/quetiapine		Percocet/oxycodone
	Cymbalta/duloxetine		Risperdal/risperidone		Fiorcet/Fiorinal
	Effexor/venlafaxine		Geodon/ziprasidone		Soma/carisoprodol
	Pristiq/desvenlafaxine		Haldol/haloperidol		Ultram/tramadol
	Wellbutrin/buproprion		Clozaril/clozapine		Ultracet
	Remeron/mirtazapine				Neurontin/gabapentin
	Trazodone/oleptro				Morphine
					Lortab/Norco/Vicodin
X	ANXIETY/SLEEP	X	BIPOLAR/MOOD		Hydrocodone
	Librium/chlordiazepoxide		Tegretol/carbamazepine		Demerol/meperidine
	Tranxene/clorazepate		Lithobid/lithium		Lyrica/pregabalin
	Restoril/temazepam		Depakote/valproic acid		Codeine
	Serax/oxazepam		Lamictal/lamotrigine		Duragesic/fentanyl
	Buspar/buspirone		Topamax/topiramate		
	Ambien/zolpidem		Trileptal/oxcarbazepine		
	Klonopin/clonazepam	X	LONG-ACTING INJECTIONS	X	OTHER
	Valium/diazepam				
	Ativan/lorazepam		Haldol/Decanoate		Cogentin/benztropine
	Xanax/alprazolam		Risperdal Consta		Naloxone
	Lunesta/eszopiclone		Invega Sustenna		Inderal/propranolol
	Sonata/zaleplon				Metformin/glucophage
					Synthroid/levothyroxine
X	ADHD/STIMULANTS	X	MEMORY/DEMENTIA		Vistaril/hydroxyzine
	Vyvanse		Aricept/donepezil		
	Modafanil/Provigil		Namenda/memantine		
	Phentermine		Exelon/rivastigmine		
	Armodafanil/Nuvigil				
	Focalin/dextroamphetamine	X	SUBSTANCE ABUSE		
	Adderall/methylphenidate		Suboxone/Subutex/buprenorphine		
			Methadone Chantix/		
			arenicline Vivitrol/naltrexone		

ACKNOWLEDGEMENT OF PATIENT POLICIES
American Psychiatric Care, LLC
Phone: 410-670-3076 Fax: 443-372-5365
www.americanpsychcare.com

By reserving an appointment with American Psychiatric Care, LLC, the undersigned agrees to abide by the following:

I understand if I arrive 15 minutes late to my appointment *I may not be seen and must reschedule.*

Payment:

- **Payment is due at the time of service** (Co-pays, deductibles, co-insurance)
- Our office does not make a practice of completing patient forms; however, we will review requests for form completion on a case by case basis. Forms may take 5 to 7 business days to complete. Completion of certain forms may require a fee.
- Cash and credit cards are accepted; however, we do not accept checks.

Appointment Cancellations:

- Once you have scheduled an appointment, you may cancel it without incurring a charge only if you provide notice at least twenty-four (24) hours in advance at the above phone number. If you do not provide timely notice, you will be charged $50. This fee must be paid prior to your next appointment.

"No-Shows":

- A "no-show" is someone who misses an appointment without cancelling it in the proper manner. A failure to be present at the time of the scheduled appointment will be recorded in your medical record as a "no-show". If you are a no-show for your first appointment with a physician or physician assistant, you will be charged $200. If you are a no-show for your first appointment with a therapist, you will be charged $100. A credit card or debit card is required prior to your first appointment. Please fill out the credit card information at the bottom of page 3.
- For each "no-show" follow-up appointment, you will be charged $50. All no-show fees must be paid prior to your next appointment.
- If you have two (2) or more "no-shows" you may be discharged from the practice

Emergencies/ After Hours:

- During normal business hours call 410-670-3076, and the receptionist will set up an emergency appointment for you.
- For after-hours emergencies, Call 911 or go to the nearest emergency room

Call Harford County Mobile Crisis Team: 1-800-639-8783
Call Baltimore County Mobile Crisis Team: 410-931-2214

Medications:

- All prescriptions are sent to the pharmacy using encrypted technology via the internet.
- Schedule and keep the appointments recommended by your psychiatrist to keep your medications current. It is your responsibility to attend all scheduled appointments before your medications run out.
- If you miss an appointment or run out of medications before your next appointment, contact our office to discuss your medication needs. Medication refills, without an appointment, are reviewed on a case by case basis.
- Please allow 48 hours for medication refills and prior authorizations.

Confidentiality:

American Psychiatric Care will only release your confidential information if there is:

1. Written consent from the patient
2. An indication that clear and immediate danger exists to self or others
3. A court order directing the release of information
4. Disclosure of sexual abuse, physical abuse, or neglect of a child under the age of 18
5. Information necessary for your insurance carrier to insure that your treatment is medically necessary and appropriate

Patient Testimonial/ Review:

By signing this notice, I understand and acknowledge that if I voluntarily share a testimonial/review on the company website about your services, it will be distributed to Solution Reach, Google, and possibly other social media pages. Any personal information I choose to disclose is not protected. American Psychiatric Care, LLC , is not responsible for any personal information being released when distributed voluntarily.

Notice of Privacy Policies:

You have been provided with a copy of our Notice of Private Policies and a consent before signing this Acknowledgment You have the right to revoke your consent at any time by notifying us in writing. The revocation will not affect any actions taken prior to the time you revoke it. You have the right to restrict the use of your health care information; however, we are not required to agree to any restrictions. If any restrictions are agreed upon, the agreement is binding on use.

Advance Directive for Medical Health Treatment:

Maryland law states that you have the right to make decisions in advance, including mental health treatment decisions, through a process called advance directive. *An advanced directive can be used to state your treatment choice or can be used to name a health care agent, who is someone that will make health care decisions for you.* **Please indicate if you would like us to provide you with a copy of the Advance Directive for Mental Health Treatment. ___Yes ___No**

Policy Agreement:

I understand that American Psychiatric Care, LLC, has reserved my appointment in consideration of my promise to abide by the above policies and my agreement to make payment is outlined.

I have read all the information above and am in agreement with the policies and procedures presented. By signing below, I authorize American Psychiatric Care, LLC to charge the below card for any copay, deductible, or self-pay amount that I am responsible for on the day of my appointment. I understand that if my insurance company denies payment for Telemedicine/ Teletherapy, I will be liable for the payment. If I no-show or cancel an appointment not giving 24 hours' notice, I understand a $50.00 fee will be charged to this card.

Name:_____ Date of Birth:_____

Signature:_____ Date:_____

Credit Card Information

Name:_____

Credit Card Type: VISA MC AMX DEBIT

Number:_____ Expiration Date:_____

Security Code:_____

Number of Street Address:_____ Zipcode:_____

Patient Name: _____ Date of Birth: _____ Date:_____

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

Your Rights: When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

You can ask to see or get an electronic or paper copy of your medical record and health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee. You can ask us to correct health information about you that you believe is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days. You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests. You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree with your requests, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment of our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you asked, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable cost-based fee if you ask for another one within 12 months. You can ask for a paper copy of this notice at any time, and we will provide you with a paper copy promptly. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

You can complain if you feel we have violated your rights by contacting us at American Psychiatric Care L.L.C., 2014 S. Tollgate Road, Suite 208, Bel Air, MD 21015. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/regulations/complaints-and-appeals/index.html. We will not retaliate against you for filing a complaint.

Your Choices: For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

You can tell us to share information with your family, close friends, or others involved in your care; share information in a disaster relief situation; or include your information in a hospital directory. *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest.* We may also share your information when needed to lessen a serious and imminent threat to health or safety.

We will never share your information unless you give us written permission for marketing purposes, sale of your information, and most sharing of psychotherapy notes.

How do we typically use or share your health information? We can use your health information and share it with other professionals who are treating you. We can use and share your health information to run our practice, improve your care, and contact you when necessary. We can use and share your health information to bill and get payment from health plans or other entities.

We are allowed or required to share your information in other ways, usually in ways that contribute to the public good; such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/index.html. We can share health information to help with public health and safety issues for certain public health and safety issue situations such as preventing disease, helping with product recalls, reporting adverse reactions to medications, reporting suspected abuse, neglect, or domestic violence, preventing or reducing a serious threat to anyone's health or safety. We can share your information for health research. We will share your information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy laws. We can share health information about you with organ procurement organizations. We can share health information with a coroner, medical examiner, or funeral director when an individual dies. We can use of share health information about you for workers' compensation claims, for law enforcement purposes or with a law enforcement official, with health oversight agencies for activities authorized by law, and for special government functions such as military, national security, and presidential protective services. We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities: We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

We can change the terms of this notice, and the changes will apply to all the information we have about you. The new notice will be available upon request, in our office or on our website.

Acknowledgment:
I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Patient Signature:_____ Date:_____

Patient Name:_____ Date of Birth:_____

CONSENT TO TREAT A MINOR

i. GENERAL CONSENT FOR TREATMENT: THIS CONSENT EXPIRES IN ONE YEAR

a) I hereby consent to the performance of routine evaluation/ treatment or other related services for **PATIENT:**_____, **DATE OF BIRTH:**_____to include medical, psychological, and medication management services considered necessary or desirable in the judgment of the professional staff of American Psychiatric Care, LLC.

b) I acknowledge that no guarantees have been made regarding results of evaluation/ treatment by the staff of APC.

c) I acknowledge that the purpose of this consent for treatment has been explained to my satisfaction and that I understand its contents.

ii. AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI): THIS AUTHORIZATION EXPIRES IN ONE YEAR- PHI includes information that identifies you and tells about your past, present, or future physical or mental health or condition, and related healthcare services, including your billing records. PHI includes your health information created or received by APC. I understand that APC may use and disclose PHI for treatment, payment, and healthcare operations without my authorization.

Primary Care Provider: _____

Address: _____ City:_____ State:_____ Zip: _____

iii. A. EMAIL AUTHORIZATION

Emails may contain confidential information as well as PHI. Please note that APC does not guarantee that emails will be confidential or secure. Your use of email constitutes your acknowledgment and understanding of these confidentiality and security risks and limitations. By providing an email address below, I consent to email as a form of communication with APC and its professional staff. This includes the emailing of medical reports.

Email Address: _____

B. TEXT AUTHORIZATION

By providing a cell phone number below, I consent to receive text messages for appointment reminders. I understand that some cell phone plans may charge for these text messages and that text messages are not secure.

Phone #: _____

iv. COMMUNICATION/ TELEMEDICINE CONSENT

a) **Telepsychiatry** is the delivery of psychiatric services using interactive audio, visual (video), or other telecommunications or electronic technology where the licensed healthcare provider and the patient are not in the same physical location. The interactive electronic systems incorporate network and software security protocols to protect patient information and safeguard the data exchanged.

I **do** consent:_____ I do **not** consent:_____

b) **Communication Method:** I understand that each patient's care depends on communication among all care providers, and that APC providers communicate with each other and outside providers using the most appropriate means of communication, which may include electronic or video-based communication. I understand that, although no method of communication is completely secure, APC uses all reasonable and legally required means to maintain the privacy and security of my personal information.

v. COURT ORDERS

****If parents are divorced or separated please fill out this section****

Is there a court order that restricts either parent from obtaining information related to the child[ren]'s medical handling and/or consenting to medical treatment on behalf of the patient[s]? **Yes** / **No**

If yes, please briefly explain below and provide the supporting documents so they can be kept on file. *
(*It will be assumed both parents have "joint legal custody" unless there is an authorized document stating otherwise*)*

_____

_____

Parent or Legal Guardian:_____ Relationship to Patient: _____
Print

Signature: _____ **Date:** _____