PSYCHIATRY CENTER OF FREDERICK
NEW PATIENT REGISTRATION FORM
(Please complete all information)

Initial Appointment Date:				Self Pay❑	Insured❑	
Provider of Service ❑Dr. Allan L. Levy	❑Wendy Levy ,LCPC		❑ Gail Click, LCSW			
PATIENT INFORMATION						
Patient's last name: First: Middle:				❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Widow
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Social Security no.:	Birth date: / /	Age:	Sex: ❑ M ❑ F	
Street address:		Home phone no.: ( )	Cell phone no.: ( )			
P.O. box:	City:	State:	ZIP Code:			
Occupation:	Employer:	Employer phone no.: ( )				
Emergency Contact Name :		Emergency Contact Number:				
Primary Care Physician:		Phone #:				
Spouse 's Name:		Spouse's DOB:	Phone #:			
Parent's Name(s) if Minor:		Phone #:				
PRIMARY INSURANCE INFORMATION						
(Please give your insurance card to the receptionist.)						
Insurance Name:						
Policy Holder 's Name:	Member ID:	Group #				
Policy Holder SS#:	Policy Holder's DOB:					
Policy Holder's Employer:						
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other		
Name of secondary insurance (if applicable):	Subscriber's name:	Policy #:	Group #.:			
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other		

READ AND SIGN BELOW

I understand that Dr. Allan L. Levy does not complete disability evaluations for more than three months for patients he is treating.

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to ALLAN LEVY, MD, PC. I understand that I am financially responsible for any balance not covered by insurance. I also authorize Allan L. Levy MD, PC or insurance company to release any information required to process my claims. I understand that filing claim with my insurance company or other third party payer, under any circumstances, does not relieve me from my responsibility for the payment of all charges, I further acknowledge that I am responsible for the payment of all charges for services rendered by Dr. Allan L. Levy's practice to me or the patient indicated. By signing this document I will guarantee the payment of these charges for medical services rendered.

_____ _____

Patient/Guardian signature *Date*

PSYCHIATRY CENTER OF FREDERICK
ALLAN L. LEVY, MD, PC
172 THOMAS JOHNSON DRIVE
SUITE 204
FREDERICK, MD 21702
TELEPHONE: 301-663-8343
FAX: 301-695-0746

Psychiatric Services

Pastoral Counseling
Gail L. Glick, LCSW
Dr. Wendy A. levy, Executive Director

CONSENT TO THE USE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATION

I understand that as part of my healthcare, Dr. Allan Levy/Psychiatry Center of Frederick originates and maintain health records describing my health history. symptoms, examination and lab results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communications among the many health professionals who contributes to my care
- A source of information for applying my diagnosis and procedural information to my bill
- A means by which a third party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that Dr. Allan Levy/Psychiatry Center of Frederick reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided, upon written request to do so. I understand that I have the right to see and obtain copies of my medical record upon written request and during normal business hours and a designated time set by Dr. Allan Levy/Psychiatry Center of Frederick. I understand that I have the right to request amendments be made to my medical record. All amendments need to written on separate sheet of paper and duly indicated "amendment to the record". I understand that a five-year history of all disclosures will be accessible to me including the purpose of the disclosure and the address of the recipient. I may receive a copy of this history within 60 days of my written request and I understand that I may have to pay a reasonable charge for any copies. I understand that I have the right to request restrictions as to how my health information may be used or disclose to carry out treatment, payment or healthcare operations and that the practice is not required to agree to restrictions requested. If Dr. Allan Levy/Psychiatry Center of Frederick does agree to any restriction, the agreement is binding on use. I understand that I may revoke this consent in writing, except to the extent that the practice has already taken action in reliance thereon.

I request the following **restrictions** to the use or disclosure of my health information:

_____

_____

_____

I hereby consent to the use and disclosure of my individually identifiable health information for treatment, payment and healthcare operation purposes

_____
Patient's Name (please print)

_____ _____
Signature of Patient or Legal Representative Date

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PATIENT FINANCIAL POLICY FORM

Patient Name: _____ Date of Birth: _____

We are privileged you have chosen us as your health care provider. We are committed to providing you with quality patient care. The following is a statement of our Financial Policy, which you need to understand prior to treatment. If you have any questions, please feel free to ask us before signing this form. It is your responsibility to notify our office of any patient information changes (i.e. address, name, insurance information, etc).

FULL PAYMENT IS DUE AT TIME OF SERVICE. We accept cash, checks, and most major credit cards. There will be a $25.00 fee on all returned checks.

Regarding Insurance

It is the responsibility of the insured to know what their eligibility and coverage is with their insurance carrier. Although we will verify your coverage and calculate your deductible and copayments as accurately as possible, please understand that all treatment plans given are only an estimate based on the information your insurance company provides. **All *deductibles, co-insurance, co-payments and non-covered*** services are due the day the treatment is rendered. It is the insurance company that makes the final determination of your financial obligations and eligibility for services. You agree to pay any portion not covered by your insurance. Your insurance policy is a contract between you and your insurance company. We have no control over their decisions and the amount they decide to pay. ***If you have not met your deductible*** – you may receive a statement with additional balances after your claim has been processed by your insurance.

Referrals and Prior-authorization

If your insurance company requires a referral and/or prior-authorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower or no payment from the insurance company, and the balance will be your responsibility.

Self-Pay Patient

If you are a self-pay patient **payment in full** is due at the time of your service.

Missed Appointment/Late Cancellation

In the event that you cannot keep your appointments, 24hour notice is required to avoid a "No Show/Late cancel" fee of **$40.00** charged to your account for established patient and **$100.00 for new patient appointment**.

I have read and understand the above Financial Policy. By signing below, I acknowledge responsibility and agree to the terms above.

_____ _____

Signature of Patient/ Responsible Party Date

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PATIENT COMMUNICATION CONSENT FORM

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 is a federal Law. The administrative simplification section of this Act is of concern to our practice and requires us to comply with specific rules regarding:

- Unique Identifiers for health plans, providers, individuals and employers
- Healthcare transactions and code sets for transmitting electronic data
- Privacy regulations over disclosure and use of health information
- Security regulations over protection of electronic health information

All of these rules have been developed by the Department of Health and Human Services and will become final in a staged manner.

It is our ***policy*** not to release any confidential and /or unauthorized information by home telephone, work telephone, answering machine, voicemails, cellular phone, email or fax. When returning telephone calls we will not leave a message if the name or telephone number is not on the recorded message to identify the patient or responsible party. Information will not be left with any unauthorized person who may answer the phone if their name is not listed on this form.

If you would like to have your medical information released and appointment scheduled or confirmed to someone other than yourself, please complete following:

I_____ authorize Psychiatry Center of Fredrick/Dr. Allan L. Levy to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes.
****PLEASE NOTE: If nothing is checked, we will assume permission is NOT given** ***

Psychiatry Center of Fredrick/Dr. Allan L. Levy can contact me anywhere reasonably necessary for medical care.

Home Number: _____	YES	NO
Cellular Number: _____	YES	NO
Work Number: _____	YES	NO
Answering Machine/Voice Mail _____	YES	NO

Please list name of Individual that we can release information to and also can schedule/confirmed your appointment:

Spouse/Finance: _____	YES	NO
Parents: _____	YES	NO
Brother/Sister: _____	YES	NO
Son/Daughter: _____	YES	NO
Other (specify) _____	YES	NO

_____ _____
Patient/Guardian Signature Date

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*** You May Refuse to Sign This Acknowledgement***

By signing this form, you acknowledge receipt of Notice of Privacy Practice of Psychiatry Center of Frederick. Our Notice of Privacy Practices provides information about how we may use and disclose your Protected Health Information; we encourage you to read entirely before signing.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting our office at 301-663-8343

I, _____, have received a copy of t Notice of Privacy Practices for Psychiatry Center of Frederick (Dr. Allan L. Levy).

_____ _____
Signature of patient (**Parent signature if minor**) Date

For Office Use Only
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

Signature of Provider Representative: _____ Date: _____

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NOTICE OF PRIVACY PRACTICES

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.

Our Pledge Regarding Medical Information:
We understand that medical information about you and your health is personal. We are committed to protect medical information about you. We create a record of the care and services you receive at Psychiatry Center of Frederick. We need this record to provide you with quality care and to comply with certain legal requirements. We are required by law to make sure that medical information that identifies you is kept private, to make available to you this notice of our legal duties and privacy practices with respect to medical information about you, and to follow the terms of the notice that is currently in effect.

Your Authorization: Except as outlined below, we will not use or disclose your protected health information for any purpose unless you have signed a form authorizing the use or disclosure. You have the right to revoke that authorization in writing unless we have taken any action in reliance on the authorization
Uses and Disclosures for Treatment and Payment: We will make uses and disclosures of your protected health information as necessary for your treatment. We may use protected health information, to converse or by written means with pharmacies or pharmaceutical companies that may be of interest to the individual patient. We will make uses and disclosures of your protected health information as necessary for the purpose of payment and those health professionals that have treated you or provided services to you.
Family and Friends Involved in Your Care: With your approval, we may from time to time disclose your protected health information to designated family, friends, and others who are involved in your care or in payment of your care in order to facilitate that person's involvement in caring for you or paying for your care.
Appointments: We may contact you to provide appointment reminders for your follow-up visit, if you wish appointment reminders to not be left on voicemail; you may request such confidential communication in writing or call our office to notify us about that.
Other Uses and Disclosures: We are permitted or required by law to make certain other uses and disclosures of your protected health information without your consent or authorization. An example would be for public health requirements, court order or to report child abuse. We have chosen to participate in the Chesapeake Regional Information System for our Patients, Inc. (CRISP), a statewide health information exchange. As permitted by law, your health information will be shared with this exchange in order to provide faster access, better coordination of care and assist providers and public health officials in making more informed decisions. You may "opt-out" and disable all access to your health information available through CRISP by calling 1-877-952-7477 or completing and submitting an Opt-Out form to CRISP by mail, fax or through their website at www.crisphealth.org.

RIGHTS THAT YOU HAVE
Access to Your protected health information: You have the right to copy and/or inspect much of the protected health information that we retain on your behalf. All requests for access must be made in writing and signed by you or your representative. We will charge you a fee that is consistent with state law if you request a copy of the information.
Restrictions on Use and Disclosure of Your protected health information: You have the right to request restrictions on certain uses and disclosures of your protected health information for treatment, payment, or health care operations. You have the right also to restrict the release of information to your health plan if services paid in full and out of pocket. We are not required to agree to your restriction request but will attempt to accommodate reasonable requests when appropriate and we retain the right to terminate an agreed-to restriction if we believe such termination is appropriate. We will also notify you for any breached of unsecured protected health information.
Any person /patient may file a complaint to the practice and to the secretary of Health and Human Services if they believe their privacy rights have been violated. To file a complaint with the practice, please contact the Business Office at the following phone number -301-663-8343. All complaints will be addressed and results will be reported to the Corporate Compliance Office and Managing Partners. It is Psychiatry Center of Frederick (Dr. Allan L. Levy) policy that no retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance of the privacy standards.

******PLEASE RETAIN THIS COPY FOR YOUR RECORDS******

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PERSONAL HISTORY

DEMOGRAPHICS:

Name: _____ ***Initial Appointment Date:*** _____

Date of Birth: _____ Referral Source: _____

What town do you currently live in? _____

Where did you grow up? _____

Do you have family nearby? No☐ Yes ☐ Please describe _____

MARITAL STATUS (check one):

☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Long-Term relationship ☐ Other

Years married /in a long- term relationship: _____ Times married: _____

Children (For a child list sibling):

First Name	**Age**
_____	_____
_____	_____
_____	_____
_____	_____

Who do you live with (**Check one**) ☐ Self ☐ Parents☐ children☐ Spouse☐ Other ☐

EDUCATION:

☐Graduate School☐ College ☐ Professional or Vocational School ☐ High School Grade:_____

Graduated: ☐ Yes ☐ No

Where did you last go to school? _____

What did you/are you studying? (If applicable):_____

WORK HISTORY

Are you currently employed ☐ Yes ☐ No

Name of Employer: _____

If not currently working, where were you last employed: _____

What type of work do/did you do? _____

How long have/did you work(ed) there? _____

Patient Name: _____ DOB: _____

SOCIAL LIFE

Military: _____

Branch: _____ Years: _____

Highest rank: Type of discharge: _____

Religious background Denomination (if any): _____

Religious experience: _____

LEGAL

Do you have any current legal problems: ☐ Yes ☐ No

Describe: _____

Have you ever been arrested or convicted? ☐ Yes ☐ No (**check all that apply**)

☐ DWI ☐ Drug-related ☐ Domestic violence ☐ other violent crimes

Describe: _____

MEDICAL HISTORY

Primary Care Doctor: _____ Phone: _____

Date of last physical: _____

Medication Allergies: _____ **Other allergies:** _____

Current or past medical conditions (check all that apply)

☐ Asthma/respiratory ☐ Heart, blood vessels ☐ Thyroid

☐ High blood pressure ☐ Seizures/epilepsy ☐ Nutrition

☐ Head injury ☐ GI (stomach, pancreas,etc) ☐ Back Pain

☐ Liver problems/hepatitis ☐ Diabetes/pre-diabetic ☐ Arthritis/fibromyalgia

☐ Herpes, syphilis, other STD's ☐ HIV, AIDS ☐ abnormal pap smear

Other medical illness: _____

Major hospitalization: _____

Major surgeries: _____

Current Medications (<u>not</u> including psychiatric meds): _____

_____

Vitamin supplements: _____

How is your appetite**:** _____

Have you lost or gained weight in the past 3 months: ☐ Yes ☐ No

_____ Pounds **(check one)** ☐ lost ☐ gained

Do you have trouble sleeping? (0 = No trouble 10 = Severe) _____

Hours of sleep a night: ___Trouble getting to sleep? ☐Yes ☐No Wake middle of the night ☐Yes ☐No

Tired during the day from lack of sleep? ☐Yes ☐No

Patient Name: _____ DOB: _____

Controlled Substance prescriptions:

In the past 3 months, has any healthcare provider prescribed:

Anti-anxiety medications: (Valium, Ativan, Xanax, etc.):

Doctor: _____ Medication prescribed: _____

Stimulants/ADD medication: (Ritalin, Adderal, etc):

Doctor: _____ Medication prescribed: _____

Opiates/pain medications:

Doctor: _____ Medication prescribed: _____

PSYCHIATRIC HISTORY:

Last psychiatrist Name (if applicable): _____ Last Seen: _____

What was the reason you left your last psychiatrist? _____

When (if ever) you were first treated for a psychiatric problem: _____

What was the problem? _____

What diagnoses have you been given (list the ones that you think describes your problem

1. _____
2. _____
3. _____

If you have had psychiatric hospitalizations:

When and where was the first hospitalization: _____

How many times have you been hospitalized? _____ When were you last hospitalized? _____

What happened to cause you to be hospitalized? _____

Substance Use History

Substance	**no**	**Yes /past Yes/now**	**Route**	**How Much**	**How Often**	**Date/Time Of Last Use**	***Quantity/Last Used***
Alcohol							
Cocaine/Amphetamines							
Pain pills or Heroin							
Cigarette							

Family Psychiatric history:

Relationship (Mother, cousin etc)	Diagnosis	Relationship	Diagnosis

Psychiatric medication history:

Medication	Side effects	Effectiveness	Reason stopped*

Patient Name: _____ DOB: _____

Suicide

Do you have thoughts that you would rather be dead? (Put **X**? on line)

I----------I----------I----------I

None rarely often most of the time

If you have recently thought of killing yourself, how have you thought of doing it?_____

_____

Have you ever tried to kill yourself? ☐ Yes ☐ No

If yes when and how? _____

CURRENT CONCERNS

What is the biggest reason you are seeking help? _____

_____

What are other important concerns? _____

_____

What are the biggest stressors in your life (biggest first)?

_____

How much support do you have from family (1-10):

Describe: _____

How much other support do you have from others such as work, friends, sponsors etc (1-10):

Describe: _____

How well are you functioning at home and socially? (1-10)

Describe: _____

How well are you functioning at work or school (scale of 0-10)?

Describe: _____

What are your goals for treatment (please be as specific as possible)?

1._____

2._____

3_____

4._____

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS FROM OTHER PROVIDERS

Patient Name: _____ DOB: _____

I _____ hereby authorized the provider(s) ***listed below*** to release copy of my medical record information to Dr. Allan L. Levy and also Dr. Allan Levy to release copy of my medical record information to the provider(s) listed below, to be used for continuing medical care. I reserve the right to revoke this authorization in writing at anytime. Furthermore, I understand that this Protected Health Information may be re-disclosed by the recipient and thus, is no longer protected under privacy rule.

PROVIDERS:

Primary Care Provider: _____ Phone: _____

Psychiatrist: _____ Phone: _____

Psychologist: _____ Phone: _____

Therapist/Counselor: _____ Phone: _____

Other Doctors: _____ Phone: _____

Other Doctors: _____ Phone: _____

_____ _____

Patient Signature / Guardian (if Patient is Minor) Date

By signing this authorization, I understand that medical records releases may contain information related to HIV status, AIDS, Sexually transmitted diseases, mental health, drug and alcohol abuse, etc. I understand that release of ***psychotherapy notes*** requires an additional authorization.

Notice to the recipient of these records: If the information concerns a person treated for alcohol or drug abuse, the confidentiality of this information is protected by federal law (Federal Regulation 40 CFR part2) and prohibits further disclosure of this information except with specific written authorization of the person to whom it pertains.
A general authorization for release of medical or other information is not sufficient for this purpose

Name:_____ Date:_____

Brief symptom survey

Instructions: put a check ( ) after each item to indicate how you have been feeling, during the past week, including today. Please answer all the items. Then add the scores and put the totals in the box.

	0 - Not at all	1 - Somewhat	2 - Moderately	3 - A lot	4 - Extremely
Depression	0	1	2	3	4
1. Sad or down in the dumps.					
2. Discouraged or hopeless.					
3. Low self esteem.					
4. Worthless or inadequate.					
5. Loss of pleasure or satisfaction					
Please total your score on 1 - 5 here ---------->>					
Anxiety	0	1	2	3	4
1. Anxious					
2. Frightened					
3. Worrying about things over and over					
4. Tense or on edge.					
5. Nervous					
Please total your score on 1 - 5 here ---------->>					
Alcohol and Drugs	0	1	2	3	4
1. Have you felt you ought to cut down on your alcohol or drug use?					
2. Have people annoyed you by criticizing your drinking or drug use?					
3. Have you ever had a drink first thing in the morning?					
4. Have you felt bad or guilty about your drinking or drug use?					
Please total your score on 1 - 4 here ---------->>					
Panic	0	1	2	3	4
1. Sudden feelings of terror or overwhelming fear.					
2. Sudden, terrifying panic attacks that come out of the blue.					
3. Sudden feeling you are going crazy or cracking up.					
4. Sudden feeling you are going to suffocate or pass out.					
5. Sudden feelings you are going to have a heart attack, stroke or die.					
Please total your score on 1 - 5 here ---------->>					
Mania	0	1	2	3	4
1. Irritable or high/upbeat mood.					
2. Talking rapidly or racing thoughts					
3. Impulsive actions such as fighting, spending, or reckless driving					
4. Increased activity and restlessness.					
5. Not needing much sleep.					
Please total your score on 1 - 5 here ---------->>					

Name:_____ Date:_____

Brief mood survey

Instructions: put a check ( ) after each item to indicate how you have been feeling, during the past week, including today. Please answer all the items. Then add the scores and put the totals in the box.

	0 - Not at all	1 - Somewhat	2 - Moderately	3 - A lot	4 - Extremely
Suicidal Thoughts	0	1	2	3	4
1. Do you have any suicidal thoughts?					
2.Would you like to end your life?					
Please total your score on 1 and 2 here ---------->>					
Relationship Satisfaction	0	1	2	3	4
Instructions: Place a check ( ) in the box that best describes how much satisfaction you feel in your closest relationship.					
1. Communication and openness					
2. Resolving conflicts and arguments					
3. Degree of affection and caring.					
4. Intimacy and closeness					
5. Overall satisfaction.					
Please total your score on 1 - 5 here ---------->>					
Post Traumatic Stress	0	1	2	3	4
1. Upsetting memories come into my mind over and over.					
2. I feel isolated and alienated from people.					
3. I always look out to be sure I don't re-experience upsetting events.					
4. I have flashbacks (upsetting events feel like they are happening now).					
5. I avoid things that remind me of traumatic memories.					
Please total your score on 1 - 5 here ---------->>					
Anger	0	1	2	3	4
1. Frustrated					
2. Annoyed					
3. Resentful					
4. Angry					
5. Irritated					
Please total your score on 1 - 5 here ---------->>					
Attention Deficit/hyperactivity	0	1	2	3	4
1. Hard time paying attention					
2. Difficulty following through (procrastination)					
3. Easily distracted					
4. Fidgetty/ hard time sitting still					
5. Interrupts/finishes other people's sentences					
Please total your score on 1 - 5 here ---------->>					