NEW BEGINNINGS HEALTH CARE

PATIENT ENROLLMENT FORM

LAST NAME_____**FIRST NAME**_____**MI**_____

BIRTH DATE_____**SS#**_____ **SEX:** M / F **MARITAL STATUS**: M S W D

ADDRESS_____**CITY**_____

STATE_____ **ZIP**_____ **EMPLOYER**_____

HOME PHONE_____ **CELL** _____

WORK PHONE_____ **EMAIL ADDRESS**_____

I give New Beginnings permission to text and/or email me with appointment confirmation**: Y N**

If you have special instructions regarding calls/emails and/or phone messages, please write those on this line: _____

EMERGENCY CONTACT

NAME: _____**PHONE**_____

CONSENT TO TREATMENT AND RELEASES

I, _____, do hereby consent to such psychiatric care as is necessary at New Beginnings Health Care, P.A.

Acting as Power of Attorney, I consent for _____.

I consent for treatment of my minor child, _____.
Name of Minor

I am aware that the practice of health care is both an art and a science. I acknowledge that no guarantees have been made to me as to the result of treatment at New Beginnings Health Care, P.A.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT
Effective 4/14/03, in accordance with HIPAA Privacy Practices, a signed authorization is needed if we should find it necessary to contact you.

I acknowledge I have received a copy of the HIPPA notice of privacy practices and authorize the phone numbers provided for New Beginnings calls.

_____ _____
Signature of Patient or Representative Date

_____ _____
Printed name if signature is NOT patient Relationship to Patient

(If patient or personal representative is unable or refuses to sign the form, please document the reasons on this form. Place this form in the patient's medical record).

NEW BEGINNINGS HEALTH CARE

PATIENT MEDICAL QUESTIONNAIRE

Name _____ Date_____

For what reasons are you seeking help here today?

_____

Please list inpatient or outpatient psychiatric services you have had.

_____
_____
_____

Please list any physical health problems you have had, including hospitalizations, surgeries, or ongoing medical care:

_____
_____
____
_____

PRESENT		**PAST**	
Psychiatric Medication	Dose	**Psychiatric Medication**	Dose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	
_____			

ALLERGIES: (food or medication)_____

Have you recently experienced any of the following symptoms: (Please check those which apply.)

GASTROINTESTINAL
Poor appetite _____
Nausea _____
Vomiting _____
Heartburn _____
Trouble Swallowing _____
Blood in Stools _____
Black Stools _____
Yellow Skin _____
Constipation_____
Bloating_____
Belching _____

NERVOUS & MUSCULOSKELETAL
Back Pain _____
Joint Pain _____
Headache _____
Stiff Neck _____
Muscle Weakness _____
Tremor _____
Numbness _____
Fainting _____
Tingling _____
Dizziness _____
Seizures _____

CARDIORESPIRATORY
Shortness of Breath_____
Chest Pains_____
Palpitations_____
Irregular Heartbeat_____
Swelling of Feet_____
Hoarseness _____
Asthma_____

GENITO URINARY
Blood in Urine _____
Pain on Urination_____
Frequent Urination_____
Irregular Menses____
Miscarriages_____
Vaginal Discharge_____

Has any member of your family ever suffered from:
Depression _____ Anxiety_____ Psychosis _____Dementia _____ ADHD _____
Bi-polar Disorder _____ Eating Disorder _____ Learning Disability _____ Alcohol/Drug Problem _____
Personality Disorder _____ Excessive Anger _____ Legal Problems _____

NEW BEGINNINGS HEALTH CARE, P.A.
2914 SW Plass Court, Suite D
Topeka, KS 66611

PAYMENT AND CANCELLATION POLICIES

We are pleased to have you as our patient. Your help is needed in complying with our office payment and cancellation policies, which will enable us to give you the best possible service at the lowest possible cost. Please read the following carefully and sign this form to acknowledge you are in agreement with our policies.

- I understand I am financially responsible to New Beginnings Health Care for any and all charges for services rendered.
- I authorize New Beginnings Health Care to release any medical records and other information required by my insurance company in reference to this claim.
- Co-pay or co-insurance is due on the time of service. New Beginnings will submit claims to your insurance carrier. You are responsible for any remaining balances not paid by insurance (within 90 days of service).
- I authorize New Beginnings Health Care to release billing account information to the billing service of their choice, to the responsible party on the account, and/or the following individual(s) _____ (please, include relationship to patient).
- **MEDICARE** PATIENTS ONLY: I request that payment of authorized benefits be made on my behalf and assigned to the physician or practitioner providing the services.
- Payment is due at the time of service for Self-Pay clients (e.g. no insurance or do not wish insurance to be billed).
- New Beginnings Health Care accepts Visa, MasterCard, and checks for payments. There is a $30 charge for returned checks.
- I authorize payment directly to New Beginnings Health Care of the benefits otherwise payable to me, but not to exceed regular charges at New Beginnings Health Care.
- I understand that I might be accessed a fee for completion of any third-party forms and or reports (FMLA paperwork, Disability Determination paperwork, legal, academic or other related reports requested by client).
- **Cancellation Policy:** There is a charge for appointments cancelled with less than 24 hour notice. There is an additional charge for missed appointments (i.e., No Shows). *This charge is due before the patient's next appointment and is not paid by insurance*. New Beginnings may be contacted after office hours and on weekends at 233-7138.

AUTHORIZATION TO RELEASE INFORMATION TO PHYSICIANS AND PHARMACY

- I authorize New Beginnings Health Care to share information with pharmacists as needed in reference to my treatment.
- I authorize New Beginnings Health Care to release my medical records to my primary care provider or referring clinician:

Referring Doctor _____ Phone _____

Primary Care Doctor _____ _____ Phone _____

I have read and authorize the above release statements and billing policies.

_____ _____
Signature of Patient (18 years or older) Date

or

_____ _____
Guardian Signature Date

New Beginnings Health Care, P.A.
Treatment Plan: Patient Perspective

Name:_____ DOB:_____ Date:_____

Why I came for treatment:
What I want to accomplish while in treatment:
How I plan to do this:

Things I don't like about myself:
Things I like about myself:

Patient Signature:_____ Date:_____