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

PAYMENT POLICY

We are pleased to have you as our patient. Your help is needed in complying with our office payment policy, which will enable us to give you the best possible service at the lowest possible cost.

- CHARGES FOR MISSED APPOINTMENTS There is a charge for appointments cancelled with less than 24 hour notice. 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.
- Co-pay or co-insurance is due on the DATE 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).
- NBHC 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 I am financially responsible to New Beginnings Health Care for any and all charges for services rendered. I have received a copy of New Beginnings Health Care's payment policy and agree to comply with the policy.
- I understand that I might be accessed a fee for completion of any third-party forms and or reports.

AUTHORIZATION TO RELEASE INFORMATION:

- I authorize New Beginnings Health Care to release any medical records and other information required by my insurance company in reference to this claim.
- 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:

Doctor ______________________________ Phone _________________________

Other Provider _________________________ Phone __________________________

- **AUTHORIZATION to RELEASE BILLING INFORMATION**: 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.

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

_________________________________ ________________

Signature of Patient (14 years or older) Date

or

________________________________ ________________

Guardian Signature Date

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).