ADULT
NEW PATIENT PACKET

WAKE
PSYCHIATRY

PATIENT INFORMATION DOCTOR:_____

DATE:____/____/____ SS # _____-_____-_____ DOB:____ /____ /_____

NAME:_____
(last) (first) (middle)

ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

PHONE (HOME):_____ (CELL):_____

EMAIL:_____ GENDER: M F Marital Status _____

APPOINTMENT REMINDER PREFERENCE: ( ) TEXT ( ) EMAIL

ETHNIC BACKGROUND

( ) White / Caucasian ( ) Black /African-American ( ) Hispanic / Latino ( ) Asian

( ) Native Hawaiian / Pacific Islander ( ) American Indian / Native Alaskan ( ) Other:_____

Do you smoke? ( ) Yes ( ) No If yes, how much do you smoke? _____

EMPLOYER:_____OCCUPATION:_____

HIGHEST EDUCATION LEVEL COMPLETED ( ) Some High School ( ) High School

( ) Some College ( ) 2-year College Degree ( ) 4-year College Degree ( ) Graduate Degree

SPOUSE/PARTNER NAME: _____

CHILDREN (Name and age)	SIBLINGS (Name and Age)
_____	_____
_____	_____
_____	_____
_____	_____

EMERGENCY CONTACT:_____

RELATIONSHIP:_____ PHONE: _____

PRIMARY CARE DOCTOR:_____ PHONE: _____

PAST ILLNESSES:_____

ALLERGIES:_____

PREFERRED PHARMACY:_____

INSURANCE COVERAGE

PATIENT NAME:_____

INSURANCE COMPANY_____

CUSTOMER SERVICE PHONE#:_____

MENTAL HEALTH PHONE# (IF DIFFERENT): _____

POLICY HOLDER (SUBSCRIBER) NAME:_____

RELATIONSHIP TO PATIENT: _____

POLICY HOLDER (SUBSCRIBER) ADDRESS:_____

_____

POLICY HOLDER DOB: ____ / ___ _____ POLICY HOLDER SS#_____-____-_____

SUBSCRIBER ID#_____ GROUP#_____

Please note that we file with primary insurance only. Our office does not file out-of-network or secondary insurance claims.

Wake Psychiatry, PLLC
Financial Policy

Thank you for choosing Wake Psychiatry for your psychiatric care. We are committed to providing the highest quality of treatment. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy. Please read and sign prior to your first appointment.

Full payment is due at the time of service. We accept cash, check, Visa or MasterCard.

Our providers are credentialed with several insurance providers. If we are not contracted with your insurance carrier, you are responsible for full payment at the time of service. If you have a deductible, you are responsible for paying each visit in full at the contracted rate for your insurance carrier until you have met your deductible obligation with the carrier. If your insurance carrier requires a co-payment, this is to be paid at each visit. Please notify the office if you have a change in insurance coverage. Authorizations for your first visit are your responsibility.

Our practice is committed to providing the best treatment for our patients and we charge the usual and customary rate for our area. You are responsible for payment for services rendered regardless of any determination made by an insurance company of usual and customary rates or non-charges.

Insurance will not pay for missed appointments. Unless cancelled at least 24 hours (business day) in advance, it is our policy to charge the office rate for the missed appointment. Reminder calls and/or emails are considered only a courtesy. You are ultimately responsible for keeping a record of the day and time of your appointment.

Each visit, you will receive a receipt which will show whether there is a balance on your account. Insurance carriers sometimes take a while to collect. The office staff will notify you if there is a balance due that is your responsibility.

Please let us know if you have any questions or concerns.

I have read the policy and agree to the terms.

_____ _____

Signature of Patient or Guardian Date

Notice of Privacy Practices

Our Notice of Privacy Practices may be found on our website at www.wakepsychiatry.com. You may also obtain a copy of this notice from our office staff. By signing below, you acknowledge receipt of this notice. You may refuse to sign this acknowledgement. Please understand that should you refuse to sign, Wake Psychiatry, PLLC will not be able to file to your insurance and you would be fully responsible for all charges.

I,_____, have read or received a copy of this office's Notice of Privacy Practices.

_____

Signature

_____

Printed Name

_____

Date

Psychiatric History of Present Illness

Patient Name: _____ Date:_____

Date of Birth: ____ / ____ / _____ Gender: M F

Please briefly describe your reason for seeking psychiatric treatment:

Please describe your symptoms (include duration, onset, triggers if any):

How are you functioning at home, work, school, etc?

What are your current stressors?

If you are currently taking medications, what are they?

Have the medications been helpful?

Are there any side effects

FAMILY HISTORY:

Is there any family history of:	YES	NO
1. Bipolar Disorder		
2. Depression		
3. Anxiety		
4. Schizophrenia		
5. ADD / ADHD		
6. Seizures		
7. Chest Pains, Heart Problems, or Sudden Cardiac Death		
8. Alcohol or Drug Problems		
9. Mental Retardation or Autism		
10. Other		

Explain "other" from question 10: _____

_____

Please answer YES or NO to the following screening questions:

	YES	NO
1. Do you feel depressed?		
2. Are you experiencing changes in your sleep?		
3. Are you experiencing changes in your appetite or eating habits?		
4. Are you self-critical?		
5. Do you have thoughts of death or suicide?		
6. Do you cry frequently?		
7. Are you having difficulty concentrating or remembering things?		
8. Do you feel tired or withdrawn?		
9. Have you lost interest in usually enjoyable activities?		
10. Have you ever experienced a period of unusually elevated or extremely irritable mood?		
11. Have you ever experienced decreased need for sleep?		
12. Do you worry excessively?		
13. Do you ruminate or obsess over certain ideas?		
14. Do you feel the urge to do things to relieve your anxiety?		
15. Do you have sleep disturbance?		
16. Do you have muscle tension?		
17. Do you have difficulty focusing?		
18. Do you experience nightmares?		
19. Do you often feel irritable or overwhelmed?		
20. Do you ever have experiences that seem bizarre or unreal?		
21. Do you experience things that others around you do not?		
22. Do you have thoughts that others find unbelievable or bizarre?		
23. Do you have difficulty with losing your place in conversation?		
24. Do you have trouble focusing while reading or working?		
25. Do you act impulsively or speak out of turn?		
26. Do you struggle with lack of organization?		
27. Do you have difficulty completing tasks or with procrastination?		
28. Do you consume far fewer calories than what you consider to be adequate?		
29. Are you concerned about your weight?		
30. Do you ever induce vomiting or use laxatives due to concern about your weight?		
31. Do you have difficulty in relationships?		
32. Do you struggle with intense emotions?		
33. Do you think you perceive things differently than most other people?		
34. Are you impulsive?		
35. Are you easily frustrated?		
36. Do you ever hurt yourself intentionally?		
37. Do you use any drugs?		
38. Do you drink alcohol? (***if no, then skip questions 39-42***)		
39. Do you feel the need to reduce your alcohol intake?		
40. Do you feel guilty about your alcohol consumption?		
41. Do you ever feel annoyed by others' comments about your drinking?		
42. Do you ever need alcohol first thing in the morning?		

WAKE
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LIST OF CURRENT MEDICATIONS

Patient Name_____ Date _____

	Name	Dosage	Frequency
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____
9.	_____	_____	_____
10.	_____	_____	_____

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DISCLOSURE AND CONSENT FORM

Patient Name_____

☐ I DO want my health information shared as specified below. This authorization will expire in two years from today. I have the right to revoke this authorization at any time by stating this in writing and sending my written revocation to Wake Psychiatry PLLC.

I authorize Wake Psychiatry PLLC to release protected health information to the entities below:

1. Give Information to spouse/partner

Name: _____

Description of Information to be released:

☐ Financial/Billing

☐ Medical Information

2. Give information to a parent (if above 18), friend or family member, please list:

Name _____ Relationship to Patient_____

Description of Information to be released:

☐ Financial/Billing

☐ Medical Information

OR

☐ I DO NOT want my health information to be shared with anyone other than my insurance company. My refusal will not affect my ability to obtain healthcare treatment, payment or eligibility for benefits.

Signature _____ Date_____