PATIENT INFORMATION: **UPDATED FORM | 2023**

First Name: _____ MI: _____ Last Name: _____

Preferred: _____ Sex (Circle): M | F DOB: _____ / _____ / _____

Maiden: _____ | License/ID #_____ SS#: _____ - _____ - _____

EMPLOYMENT INFORMATION:

Employer Name: _____ Company Name:_____ Phone: (_____) _____ - _____

Physical Address: _____ Suite: _____

City: _____ State: _____ Zip: _____

CONTACT INFORMATION: **Preferred Method of Contact (Circle): Home | Mobile | Work | Email**

Cell Phone: (_____) _____ - _____ Home Phone: (_____) _____ - _____

Work: (_____) _____ - _____ Ext:_____ Email: _____@_____.com

Physical Address: _____ Apt/Ste: _____

City: _____ State: _____ Zip: _____

If mailing address is same as physical address, please check box: ☐ SAME

Mailing Address: _____ Apt/Ste: _____

City: _____ State: _____ Zip: _____

INSURANCE INFORMATION:

Primary Insurance Company Name: _____

ID#: _____ Group#: _____ Eff. Date: _____ / _____ / _____

Insurance Co. Phone: (_____) _____ - _____

Insurance Co. Address: _____ Suite: _____

City: _____ State: _____ Zip: _____

(Subscriber) Self: ☐ **If other than SELF, include the primary cardholder information below.**

First Name: _____ MI: _____ Last Name: _____

Relationship: _____ Sex (Circle): M | F DOB: _____ / _____ / _____

Cell Phone: (_____) _____ - _____ SS#: _____ - _____ - _____

Dependent Name **(EXACTLY)** as Listed on Insurance: _____

Secondary Insurance Company Name (medicare MUST be primary to complete this section):

_____

ID#: _____ Group#: _____ Eff. Date: _____ / _____ / _____

NEXT OF KIN | SECONDARY CONTACT INFORMATION:

Name: _____ Relationship: _____

Phone: (_____) _____ - _____ Email: _____@_____.com

Address: _____ Apt/Ste: _____

City: _____ State: _____ Zip: _____

PHARMACY INFORMATION:

Pharmacy Name: _____ Phone: (_____) _____ - _____

Address: _____ Ste: _____

City: _____ State: _____ Zip: _____

MEDICATION LIST

Patient Name: _____ **Date:** _____

	Name of Medication	Dosage	Frequency	Prescribed By
1.	_____	_____ **mg/g**	_____	_____
2.	_____	_____ **mg/g**	_____	_____
3.	_____	_____ **mg/g**	_____	_____
4.	_____	_____ **mg/g**	_____	_____
5.	_____	_____ **mg/g**	_____	_____
6.	_____	_____ **mg/g**	_____	_____
7.	_____	_____ **mg/g**	_____	_____
8.	_____	_____ **mg/g**	_____	_____
9.	_____	_____ **mg/g**	_____	_____
10.	_____	_____ **mg/g**	_____	_____
11.	_____	_____ **mg/g**	_____	_____
12.	_____	_____ **mg/g**	_____	_____
13.	_____	_____ **mg/g**	_____	_____
14.	_____	_____ **mg/g**	_____	_____
15.	_____	_____ **mg/g**	_____	_____
16.	_____	_____ **mg/g**	_____	_____
17.	_____	_____ **mg/g**	_____	_____
18.	_____	_____ **mg/g**	_____	_____
19.	_____	_____ **mg/g**	_____	_____
20.	_____	_____ **mg/g**	_____	_____
21.	_____	_____ **mg/g**	_____	_____
22.	_____	_____ **mg/g**	_____	_____
23.	_____	_____ **mg/g**	_____	_____
24.	_____	_____ **mg/g**	_____	_____
25.	_____	_____ **mg/g**	_____	_____

ANY ADDITIONAL INFORMATION YOU WANT US TO KNOW:

_____
_____
_____
_____
_____

NOTES (Dr. Bishop's OFFICE staff ONLY: *Information Entered: Date:* _____ *By:* _____

_____
_____
_____
_____
_____
_____
_____

PATIENT'S RIGHTS AND RESPONSIBILITIES:

Dr. Bishop and his staff will make our best efforts to assure your rights, as listed below:

- Considerate, respectful care
- Personal and informational privacy
- Access to your medical records, as described in the HIPAA regulations and the MS State Board of Medical Licensure
- Participation in the treatment planning process
- Explanation of need to transfer to another treatment setting, e.g., hospital admission, partial hospital or intensive outpatient, mental health care, another physician.
- Have information communicated in understandable terms
- Informed consent about your treatment

YOUR RESPONSIBILITIES:

- Provide complete and accurate information about your symptoms, treatment, medical conditions, complications, treatment by other physicians and/or counselors, and social/legal occupational situations that may be germane to your diagnosis/treatment.
- Actively participate in and completely with your agreed-upon treatment plan, including maintenance of: appointments, therapy, referrals, prescriptions, medication treatment, completion of rating scales, as well as the overall examination and treatment process.
- Fulfill your financial obligations for treatment in a timely manner.
- Be respectful and courteous to physician, staff, and other patients.
- Be respectful of office property.
- Utilize the complaint resolution process, as outlined in information for patients to resolve conflicts occurring within the practice.

I have read and understand the above information. I have been given the opportunity to ask questions and have any part I do not understand explained to me. I realize that this agreement is binding upon my treatment contract and any breach by either party will be viewed as a unilateral termination of the treatment contract.

Patient Signature: _____ Date: _____

PAYMENT POLICY:

I understand that Dr. Bishop does not "carry accounts". I understand that I am responsible for services rendered, with payment due in full at the time of delivery of services unless prior arrangements have been made with the consent of both parties. I understand that my insurance may pay only party of my visit and I am responsible for copayments, deductibles, or services disallowed for such issues as pre-existing illness.

I understand that unless Dr. Bishop has a PPO arrangement with my insurance company; all insurance issues are between my insurance company and me; and have no bearing on my responsibility for full payment of all services.

I understand that if I request or require a service not covered by my insurance carrier and if I have been advised in advance that the insurance is not likely to cover the service then I am responsible for payment for that service prior to being.

I understand that Dr. Bishop may utilize a collection agency or attorney and avail himself of all applicable state laws to come tell payment of unpaid balances. In such a case, I (the debtor) will be responsible for the payment of any and all fees associated with the selection process, as well as any interest at the state allowed rate on the accrued balance.

Patient Signature: _____ Date: _____

URINE DRUG SCREEN POLICY:

I understand that if Dr. Bishop prescribes a controlled medication, i.e., a benzodiazepine (Xanax, Klonopin, Valium, Ativan), sedative/sleep medication (Ambien), or stimulant (amphetamine, methylphenidate, dextroamphetamine, lisdexamfetamine, dimesylate), I will be required to submit (at minimum) 3 urine drugs screens each calendar year. I fully understand that I will be responsible for the cost of the urine drug screen. The fee for a urine drug screen in the clinic is $20 and will be due at the time of the office visit. **The urine drug screen (80305 billing code) is generally considered medically unnecessary and is performed solely for the purpose of complying with a 3rd-party (MS State Medical Board) mandate as a condition of this physician prescribing controlled medication to you.**

Patient Signature: _____ Date: _____

NOTICE OF PRIVACY POLICIES:

- With my consent, Dr. Bishop may use and disclose protected health insurance about me to carry out treatment, payment, and healthcare operations.

CONSENT GIVEN: Yes | No CONSENT DECLINED: Yes | No

- I may request a complete copy of such uses and disclosures prior to signing this consent. Dr. Bishop reserves the right to revise the Notice of Privacy Practices at any times, which may be obtained by forwarding a written request to the above address.

- With my consent, Dr. Bishop may call my home or other designated locations and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out treatment, payment, and healthcare operations, i.e., such as appointment reminders, insurance items, and calls pertaining to my clinical care.

CONSENT GIVEN: Yes | No CONSENT DECLINED: Yes | No

- With my consent, Dr. Bishop may mail to my home or other designated locations any items to assist the practice with treatment, payment, healthcare operations, appointment reminders, patient statements.

CONSENT GIVEN: Yes | No CONSENT DECLINED: Yes | No

- I have the right to request Dr. Bishop restrict how my protected health information is used/disclosed to carry out treatment/payment/healthcare operations. However, Dr. Bishop is not required to agree to the request of restriction, but if he does, it is bound by this agreement.

- By signing this agreement, I am consenting for Dr. Bishop to use and disclose my protected health information to carry out treatment, payment, and healthcare operations; and acknowledge the receipt of the Notice of Privacy Policies.

- I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

- Evaluation and treatment may be contingent upon my consent.

Patient/Legal Guardian Signature: _____ Patient Printed Name: _____

Patient/Legal Guardian Name: _____ Date: _____

MEDICATION REFILL POLICY:

- It is our policy to prescribe enough medication and refills to last until the next appointment, which is made at the time of checkout. If a patient cancels a follow-up visit and subsequently runs out of medication, our office will only give new prescriptions at the time of the in-office (face-to-face) visit with Dr. Bishop.

- It is patient's responsibility to remain current with their appointment schedule in order to receive medically necessary evaluation and monitoring prior to initiating, maintaining, or altering a medication regimen. To minimize errors and maintain patient safety, the practice will not call in, fax, or mail any medication refills in between scheduled appointments.

- If you have an emergency situation and must obtain a medication refill before your next appointment, our policy requires a call from the pharmacy. If dr. Bishop approves the partial refill, our clinic will either call or fax the pharmacy on file. This will only be filled enough to cover the patient until the next scheduled follow up appointment. We expect to have a standing appointment in the near future before providing medication refills. Please note, all partial refills are for emergency situations only. If a patient fails to keep an appointment after their prescription runs out, it is the patient's responsibility to schedule an appointment before any new medication prescriptions will be dispensed.

- We do not prescribe stimulants, benzodiazepines, and other controlled medications without evaluating the patient in the office. We will need a police report if you ask for a medication refill request for controlled medication due to a theft. If the medication has been damaged in any way and needs to be replaced, we require ALL damaged medication to be returned to our practice for pill count verification and proper disposal.

- Our clinician reserves the right to refuse refilling any medication if they believe it is clinically necessary to evaluate the patient before prescribing medication. Dr. Bishop does not accept faxed refill requests for medications that have zero refills. Per our clinic policy, all patients should be seen in the clinic for their follow-up appointment to receive any continuation or new medication. Our clinic will only accept medication prior authorizations via CoverMyMeds.

- Patient Note: Do not fill prescriptions from the practice anywhere except your pharmacy, i.e, the pharmacy listed in your chart. If you fill a prescription at a different pharmacy, also please be aware that any controlled substance prescriptions (per state law) cannot be transferred to a different pharmacy. If you fill a prescription at a pharmacy other than your home pharmacy and a problem arises, we will not write a new prescription or call in a prescription to your home pharmacy. It is the patient's responsibility to discuss the issues with the pharmacy, as there is nothing our practice can do if the proper prescription fill steps were not taken beforehand. This clinic will not call in, transfer, or write new prescriptions. A follow up appointment must take place with the duration frequency discussed at last visit.

Patient Signature: _____ Date: _____

FINANCIAL POLICY:

- **Form Fees:** (Based on length, complexity, medical decision making) Minimum fee of $50.00 and escalates in 1/6-hour increments of an additional $50.00.
- **Phone Management Fee:** $40.00 fee for managing treating any minor problems not requiring an office visit or person-to-person contact with the physician but require the physician's professional services. **All phone management fees will be due at the time of the call and billed to the credit card on file.**
- **Missed Appointments/Late Cancellations:** As of July 1, 2020, all missed appointments/late cancellations **under 24 hours (1 business day) will receive a fee of $50.00 that will be billed to the credit card on file. There will be no exceptions.**
- **Prior Authorization Fee:** $25.00 (for any medication prior authorization forms that are filled out/submitted to insurance/pharmacy by provider and/or staff **through CoverMyMeds only**)
- **Insurance:** We accept Medicare, Medicaid, Molina, Blue Cross and Blue Shield, United Healthcare and WellCare. If we are not in network with your insurance company, you will be self pay and will be responsible for the entirety of your visit.
- Examples of Self-Pay Patients: Ambetter, Aetna, BCBS-Comcast, BCBS-Nissan (Magellan/Beacon Health), CHIP, Cigna, Fox Everett, Healthsmart Benefits, Humana (Commercial, Golden Rule, Medicare), ALL Medicare Advantage Plans, MS Health Partners, TriCare, TriWest, Worker's Compensation.

REQUIRED INFORMATION BELOW

Card Information: Name: _____

Card Number: _____-_____-_____-_____

Expiration Date: _____/_____

CSV: _____

Billing Zip Code: _____

Thank you for understanding and complying with our office policies. Please let us know if you have any questions or concerns.

Patient Printed Name: _____ Date: _____

Patient Signature: _____ Date: _____

INTAKE HISTORY:

Referral Source: (circle appropriate): Self | Friend | Relative | Dr. _____ | Other: _____

For what reason are you seeking the services of Dr. Bishop? _____

_____

MEDICAL/SOCIAL HISTORY:

Medication Allergies: _____

Surgeries/Complications: _____

_____

Medical Illnesses/Complications: _____

_____

Highest Level of Education: _____ Childhood Trauma: Yes | No _____

Treatment of ADHD/ADD: Yes | No _____ Learning Disabilities: Yes | No _____

Failed Grades: Yes | No _____ School Suspensions/Expulsions: Yes | No _____

_____

Are you currently employed? Yes | No If yes, what is your start date and position? _____

If not, please explain. _____

FAMILY HISTORY:

Father:

Living (age): _____ Deceased (age): _____ Medical illnesses: _____ Psychiatric illnesses: _____

Mother:

Living (age): _____ Deceased (age): _____ Medical illnesses: _____ Psychiatric illnesses: _____

Please list any other "blood relatives" that have or that you suspect have mental pathology: _____

_____

_____

Marriage and Children:

Are you currently married? Yes | No

How many times have you been married? ____ How many biological children do you have? ____ How many step children do you have? ____

PSYCHOTROPIC MEDICATION HISTORY:

Below is a list of common psychotropic medications. Please circle all medications you have taken. In the space provided, indicate your response, when the medication was taken and for what duration (if known).

Prozac (fluoxetine), Paxil (paroxetine), Zoloft (sertraline), Celexa (citalopram), Lexapro, LuVox (fluvoxamine), Anafranil: _____

_____

_____

Wellbutrin (bupropion), Remeron (mirtazapine), Desyrel (trazodone), Effexor (venlafaxine), Cymbalta: _____

_____

_____

Ativan (lorazepam), Xanax (alprazolam), Tranxene (cholorazepate), Klonopin (clonazepam), Librium, Valium: _____

_____

_____

Risperdal, Zyprexa, Geodon, Seroquel, Abilify, Saphris, Haldon, Navane, Trilafon, Stelazine, Prolixin, Clozaril, Thorazine: _____

_____

_____

Lithium, Tegretol, Depakote, Trileptal, Topamax, Neurontin, Lyrica, Gabatril, Zonegran, Dilantin, phenobarbital: _____

_____

_____

Ambien, Lunesta, Sonata, Restoril, Halcion, Dalmane: _____

_____

Adderall, Vyvanse, Ritalin, Concerta, Focalin, Dexedrine: _____

_____

Strattera, clonidine, Tenex, Intuniv: _____

_____

Other: _____

_____

PAST PSYCHIATRIC HISTORY:

Outpatient Treatment: (Please list all previous treating physicians and/or therapists; and dates, nature, duration, and focus of treatment)

_____

_____

_____

_____

Inpatient Treatment: (Please list all previous treating physicians and/or therapists; and the dates, nature, duration, and treatment results)

_____

_____

_____

_____

Reason for Treatment: (Briefly state below the areas of concern, for which you are seeking treatment)

_____

_____

_____

_____

_____

_____

_____

_____

Instructions:
For each item below, indicate how much difficulty you have with each symptom **over the last 1 week.**

0 = None	1 = Few Times Per Week	2 = Several Times Per Week	3 = Most Days Off/On	4 = All Day Every Day

	1.	Trouble remembering events and actions of the last day or two		2.	Trouble remembering to do things I had planned to do
	3.	Trouble concentrating on and performing the task at hand		4.	Difficulty making decisions
	5	Feeling blocked in getting things done		6.	Trouble falling asleep
	7.	Trouble staying asleep/restless sleep/multiple awakenings		8.	Awakening early in the morning and unable to return to sleep
	9.	Difficulty staying alert during the day		10.	Feeling "foggy headed"
	11.	Worry too much about things		12.	Having to check and recheck what you do (uncertainty)
	13.	Spells of terror, panic, fear		14.	Having to avoid certain places, things, or activities that frighten you
	15.	Intrusive unpleasant thoughts that wouldn't leave your mind		16.	Having to repeat the same actions such as touching, counting, washing
	17.	Feeling uncomfortable eating or drinking in public		18.	Fear of drawing attention to yourself
	19.	Feeling sad, blue, tearful		20.	Blaming yourself for things, guilt
	21.	Feelings of worthlessness		22.	Thoughts of ending your life
	23.	Feeling no interest in things, NOT SEEKING OUT pleasurable activities		24.	Not ABLE to enjoy pleasurable activities
	25.	Feeling everything is an effort		26.	Feeling low energy or slowed down in movements and/or thoughts
	27.	Decreased NEED for sleep		28.	Overactive, people tell you to slow down, talking too fast, excessive energy
	29.	Excessive projects, ideas, fantastic plans, impulsive, reckless, risky behavior		30.	Feeling easily annoyed or irritated
	31.	Temper outbursts you could not control		32.	Getting into frequent arguments
	33.	Hearing words that other don't hear		34.	Feeling that most people cannot be trusted
	35.	Feeling you are watched or talked about by others			

Instructions:
For each item below, in **the last 1 week** indicate how often have you...

0 = None	1 = Some of the Time	2 = Less Than ½ the Time	3 = More Than ½ the Time	4 = Most of the Time	5 = All the Time

	1.	Felt cheerful and in good spirits		2.	Felt calm and relaxed
	3.	Felt active and vigorous		4.	Awakened feeling fresh and rested
	5.	Felt your daily life was filled with things that interest you			

Instructions:
For each item below, indicate to what degree your symptoms have…

0 = None	1 = Some of the Time	2 = Less Than ½ the Time	3 = More Than ½ the Time	4 = Most of the Time

	1.	Disrupted my work/school work		2.	Disrupted my social life/leisure activities
	3.	Disrupted my family life/home responsibilities			

REVIEW OF SYSTEMS: **(Circle the symptoms that currently apply to you)**

- Headaches
- Blurred vision
- Double vision
- Decreased vision
- Dizziness
- Ringing in the ears
- Decreased hearing
- Chest pain
- Rapid heartbeat
- Shortness of breath
- Wheezing
- Diarrhea
- Nausea
- Vomiting
- Abdominal pain
- Frequent urination
- Pain on urination
- Urinary hesitation
- Urinary incontinence
- Decreased sexual ability
- Muscle pain
- Joint pain
- Weakness
- Unsteady gait
- Tremor
- Slowed muscle movement
- Slurred speech

Other: _____

Is there anything else you would like Dr. Bishop to know for your evaluation? _____