Patient Registration and Consent for Treatment
Financial Policy, Consent for Billing & Receipt of Documents

All New Patient forms: FAX to 603-692-1070

Services Interested in: ☐Suboxone Treatment ☐ IOP ☐ Vivitrol

Name (First, MI, Last):____ **Gender**: ☐ Male ☐ Female

Date of Birth: _____/_____ /_________ **Marital Status:** ☐ Single ☐ Married **Social Security #**: _______ - _____ - _________

Mailing Address:____________________________________ **City/State:** ____________________________**Zip Code:** ___________

Street Address:____________________________________ **City/State:** ____________________________**Zip Code:** ___________

Phone (Home):________________________ **Phone** (Cell):________________________ **Phone** (Work):________________________

Email: ________________________ **Primary Care Provider:**_______________________ **Referring Provider:**_________________

*We may wish to communicate upcoming appointment information, test results and/or other information regarding your medical care. What is the best phone number for contact where we may also leave messages? ☐ Home ☐ Cell ☐ Work

Emergency Contact: ____

Relationship: ______________________________ Phone:____

- Can the above listed contact (with photo identification) pick up prescriptions if you are unavailable? ☐ Yes ☐ No
- If you would like to give us permission to discuss personal information in you medical record with someone other than yourself, please fill out the **Permission to Discuss Form**.

Race
- ☐ White
- ☐ Black or African American
- ☐ Asian
- ☐ Other: _________________
- ☐ American Indian or Alaska Native
- ☐ Native Hawaiian or Other Pacific Islander

Preferred Language
- ☐ English
- ☐ Other:_______________

Ethnicity
- ☐ Non-Hispanic or Latino
- ☐ Hispanic or Latino
- ☐ Other

Insurance Information* *(fill out completely))*

Primary Insurance: _________________________	*Secondary Insurance*: _________________________
Insurer ID#:_________________________	Insurer ID#:_________________________
Group #:_________________________	Group #:_________________________
Claims Address: _________________________	Claims Address: _________________________
Subscriber: _________________________	Subscriber: _________________________
Subscriber's Date of Birth:_________________	Subscriber's Date of Birth:_________________
Relationship to patient:	Relationship to patient:
☐ Self ☐ Spouse ☐ Other	☐ Self ☐ Spouse ☐ Other

PATIENT: Please initial this page ☐ **and continue to Page 2 for signature** CPS Update/Staff Initial ☐

Patient Registration and Consent for Treatment

Financial Policy, Consent for Billing & Receipt of Documents

Payment Policy:
We ask that you read through the financial policy and sign the bottom prior to treatment. Co-pays are due at the time of service, or full payment is due for self-pay patients unless prior arrangements have been made with our billing department. We accept cash or credit cards (Visa, MasterCard and Discover). On a limited basis checks may be accepted and there is a service charge on any returned check; payment in full will be required within 10 days of notice.

Insurance:
Our office will kindly bill your insurance company. We participate with a number of medical insurance plans that we will contact to verify eligibility and benefits. Please realize that you have the **ultimate responsibility of verifying the coverage with your insurance.** You acknowledge that we may be an out of network provider with your insurance. You are also aware that in some circumstances your insurer will send payment directly to you. You agree to endorse the insurance check and forward funds to the appropriate entity above within 30 days of receipt. You will be responsible for any balance not paid or denied by your insurance carrier. Patients who do not supply accurate insurance information will be considered self-pay. You must inform our office of any changes in your insurance, as you are the policyholder and it is your responsibility.

Insurance Referrals:
If your plan requires a referral from your Primary Care provider, it is your responsibility to obtain it before seeking treatment from us. If a claim is denied due to a lack of referral you will be responsible for charges. You understand that you are financially responsible for claims denied or not covered by your insurance carrier for failure to obtain a referral.

Missed Appointments:
If you are unable to keep your appointment you must notify the office at least 24 hours prior to your scheduled appointment as courtesy to the doctors, staff and other patients. If you cancel or “no-show” without sufficient notice, you may be subject to a fee, payable by you, not your insurance company.
Please let us know if you have any questions regarding our Financial Policy.

The above information on all pages of this document is thorough and accurate to the best of my knowledge. For any changes to the above information, I will notify the office.
I consent to evaluation and treatment by any provider at ROAD. I hereby authorize release of medical information that is necessary for my further treatment.
I authorize release of information, including treatment and protected health information to my insurance company that is needed to process payment for services. I authorize my insurance carrier to pay benefits for services rendered, directly to PMC Medical Group, LLC or any of its affiliates.
I have read and agree to the terms of the above information. I understand payment is expected at the time services are rendered and that I am responsible for any balance.

Patient Name (Please print):____ **DOB** ____________________

PATIENT/Authorized Person SIGNATURE: _________________________________ **Date:** ___________________

Authorized Person NAME (print): _______________________________________ **Relationship:** ______________

**** Receipt of Documents ***Patient:* Complete below at the ROAD Office** ****

I have received and understand the information contained in the following documents:

1. Notice of Privacy Policies
2. Patient Bill of Rights & Responsibilities
3. Patient Bill of Rights ~ Mental Health
4. Patient Complaint Procedure
5. Advance Directives Information
6. Alcohol & Drug Confidentiality Notice

PATIENT/Authorized Person SIGNATURE: ____________________________________ **Date:** _______________________

R.O.A.D. To A Better Life

Health History Form

Name: ______________________________ **Date of Birth**:_____/______/_________

Reason for today's visit: ______________________________

CURRENT MEDICATIONS

Name of Medication	**Strength** (ex. 500 mg)	**Dosing Instructions** (ex. Twice a day)

ALLERGY HISTORY

☐ No Known Allergies ☐ Medication Allergies ☐ Environmental/Seasonal Allergies ☐ Latex Allergies

Allergen (ex. Food, Dust, Animals, Pollen, Medication)	**Reaction** (ex. Rash, nausea, respiratory, shock, etc.)

SOCIAL HISTORY *(Please circle all applicable responses)*

Marital Status	Single Significant Other Married Divorced Widowed	
Sexual Orientation	Heterosexual Gay Lesbian Bisexual Transgender	
Living Situation	Alone Spouse/Significant other Children/Family Homeless Residential Other:	
Females- Are you pregnant?	Yes / No Hysterectomy Menopause Tubal ligation	
What are your hobbies?		
Education (highest level)	9 10 11 12 Some college Associates Bachelors GED Masters PhD	
Employment?	Full-time Part-time Unemployed Seeking employment Disabled Retired	
If yes, Employer:	Occupation: # of Years:	
Previous work experience?	Yes / No	If yes, description:
Military History	None / Past / Current	Army Navy Marines Coast Guard National Guard
Combat?	Yes / No	If yes, Where:
Discharge?	Yes / No	If yes: Honorable General Dishonorable Retired Other
VA Disability?	Yes / No	If yes, due to:
Spiritual/ Religious Affiliation?	Yes / No	Practicing/ Role of Faith Past & Present?
Receiving Benefits?	Yes / No	APTD SSI SSDI Food Stamps Fuel Asst. Section 8 Disability Public/HUD Housing PASS Plan Workers comp Unemployment

If applicable, amount?

Tobacco Use? *If no, have you ever?*	Yes / No Yes / No	Cigarettes / Cigars / Chew Cigarettes / Cigars / Chew	Per day: Per day:
Do you drink alcohol?	Yes / No	Beer / Wine / Liquor	Per day:
Do you drink caffeine?	Yes / No	Coffee / Tea / Soda / Energy Drink	Per day:
Do you exercise?	Yes / No	Type?	
Do you wear your seatbelt?	Yes / No	If yes, percent of time:	

R.O.A.D. To A Better Life

MEDICAL HISTORY *(Please check any of the following that you have or have had in the past)*

- ☐ Acid Reflux/GERD
- ☐ ADHD
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Bowel Problems
- ☐ Cancer
- ☐ Chronic Cough
- ☐ Chronic Pain
- ☐ COPD/Emphysema
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes
- ☐ Eating Disorder
- ☐ Glaucoma/Cataracts
- ☐ Headaches
- ☐ Hearing Loss
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ Kidney Disease
- ☐ Immune Disorders
- ☐ Liver Disease
- ☐ Osteoporosis
- ☐ Seizure Disorder
- ☐ Sexually Transmitted Disease
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Other: __________

- Are you/do you have: Obsessive compulsive? __________ Eating disorder? _________ Panic Attacks?_________
- Have you participated in high-risk sexual practices?_________ If so, please describe: ___________________________________
- Have you had Hepatitis? Yes ☐ No ☐ Venereal Disease? Yes ☐ No ☐ Last HIV test ____________

  Results? ____
- Do you now have, or have you ever had, seizures or convulsions? Yes ☐ No ☐

  If yes, when, and what condition caused them? _______________When was the last seizure or convulsion? ______________

For Women Only:

At what age did you start to menstruate? _______

Do you now have, or have you had, any problems with your menstrual period? ☐ Yes ☐ No

If yes, please describe these problems: ____

Have you had any:

Pregnancies? Yes ☐ No ☐ If yes, how many? _________ When? _________ Were you using? _________

Miscarriages? Yes ☐ No ☐ If yes, how many? _________ When? _________ Were you using? _________

Abortions? Yes ☐ No ☐ If yes, how many? _________ When? _________ Were you using? __________

Menopausal symptoms or treatment? If yes, when?_______________________

For Men Only:

Do you now have, or have you had, problems with your prostate, difficult or painful urination, or impotence?

Yes ☐ No ☐ If yes, please describe those problems: ____

FAMILY HISTORY (*Please tell us about your immediate family)*

CHILDREN ☐ None

First Name	Last Name	Age	Living With?	Custody?	Quality of Relationship
			Yes / No	Yes / No	
			Yes / No	Yes / No	
			Yes / No	Yes / No	
			Yes / No	Yes / No	

SPOUSE/SIGNIFICANT OTHER ☐ None

Name	Age	Occupation	Quality of Relationship

Relationship	Age	Marital Status	Occupation	Living with?	Quality of Relationship
Mother				Yes / No	
Father				Yes / No	
Sibling:				Yes / No	
Sibling:				Yes / No	
Sibling:				Yes / No	
Other:				Yes / No	
Place of Birth:			**Place of upbringing**:		
Family is:	Intact	Parents Separated/Divorced	Parents Remarried		
Resided with:	Mother	Father	Adopted	Orphaned	Other:

Health History	Father	Mother	Siblings	Children	Other
Age at Death					
Cause of Death					
Heart Disease/ Stroke					
High Blood Pressure					
Diabetes					
Cancer (type)					
Epilepsy					
Asthma					
Blood Disease					
Other:					

Contact with Family (check all that apply)

- ☐ Visit at least monthly
- ☐ Involved with treatment providers
- ☐ Family is available locally
- ☐ Supportive
- ☐ Knowledgeable about mental illness
- ☐ Family members not available
- ☐ Non-supportive
- ☐ Involved in NAMI or other support group
- ☐ Satisfied with family/relationship contact
- ☐ Not satisfied with family relationship/contact

SUBSTANCE ABUSE HISTORY

Family Substance Abuse (*Please check any family that apply, and list substance abused)*

☐ None ☐ Parents:________________ ☐ Siblings:________________ ☐ Extended Family:_________________

Do you or your family think you have a problem with:

Shopping? Yes ☐ No ☐ Barbiturates? Yes ☐ No ☐ Internet? Yes ☐ No ☐

Sex Addiction? Yes ☐ No ☐ Gambling? Yes ☐ No ☐

Have you had any previous rehab or **treatment of substance abuse?** Yes ☐ No ☐

Where?	Reason there?	How Long?	In patient/ Outpatient?	Date

(Please indicate which of the following drugs you have used, if any)

Substance	Age at first use	How often you use	How much you use	Method (s) you use	How long since last use
Alcohol					
Methamphetamine					
Amphetamine					
Barbiturates					
Cocaine (powder)					
Cocaine (crack)					
Hallucinogens					
Heroin					
Methadone					
Morphine					
Opium					
Inhalants					
Marijuana/Hashish					
PCP (Angel Dust)					
Ketamine (Special K)					
Ecstasy (x)					
Other: ________________					

Did/do you go to "meetings?" ___________________________ Do you have a sponsor? ___________________________________

Do you see a psychiatrist and if so who and how long? ____

Do you see a therapist or counselor and if so who and how long? ____

Have you ever been treated for depression if so when? ____

LEGAL HISTORY (*Please report any and all legal issues)*

<table>
<tr><td>Legal or Criminal Involvement?</td><td>Yes / No</td><td colspan="3">Court order   Probation   Parole   Restraining Order</td></tr>
<tr><td colspan="5">Found not competent to stand trial   Homicide or attempted homicide   Sexual Assault   Arson   Assault   Felony</td></tr>
<tr><td>Probation/Parole Officer</td><td>Current / Past</td><td colspan="2">Name:</td><td>County:</td></tr>
<tr><td>DUI (date):</td><td colspan="3">Warrants (date):</td><td>Violent Crime (date):</td></tr>
<tr><td colspan="2">Incarceration, date(s):</td><td colspan="2">How long:</td><td>Reason:</td></tr>
<tr><td>Do you have firearms at home?</td><td>Yes / No</td><td colspan="2">If yes, Are they locked?</td><td>Yes / No</td></tr>
</table>

MENTAL HEALTH

Stressful events over the last year:

- ☐ Recent Hospital Discharge
- ☐ Death/ Divorce/ Separation
- ☐ Relationship problems
- ☐ Move
- ☐ Educational Problems
- ☐ Housing Problems
- ☐ Access to Healthcare
- ☐ Witness/Victim of Violence
- ☐ History/Current Abuse
- ☐ Disability (self or family)
- ☐ Parenting Issues
- ☐ Job Loss
- ☐ Financial Problems
- ☐ Legal Problems
- ☐ Social/Environmental Problems
- ☐ Other Family Problems
- ☐ Health Problem: _____________
- ☐ Other: ____________________

R.O.A.D.
To A Better Life

Please check symptoms experienced in the last 4 weeks:

MOOD ☐ Depression ☐ Anxiety ☐ Hopelessness	☐ Mood Changes ☐ Sadness ☐ Elation (happier than normal) ☐ Anger/Rage	☐ Overwhelming guilt/shame ☐ Difficulty enjoying life ☐ Irritability
BEHAVIORS ☐ Hurting yourself ☐ Doing the same thing repeatedly	☐ Uncontrolled spending/gambling ☐ Increased alcohol/drug use	☐ Reckless behavior ☐ Social Isolation
PHYSICAL ☐ Increased Sleep ☐ Decreased Sleep ☐ Difficulty Sleeping	☐ Panic/ Anxiety Attacks ☐ Increased Appetite/ weight gain ☐ Decreased Appetite/ weight loss ☐ Disturbing nightmares/dreams	☐ Agitation/Restless ☐ Unusual sensory experience (smell, taste) ☐ Other (specify):
THINKING ☐ Wanting to take your life ☐ Wanting to hurt someone else ☐ Seeing/Hearing things that aren't there ☐ Difficulty concentrating	☐ Intrusive negative thoughts ☐ Flashbacks ☐ Irrational fear ☐ Racing thoughts ☐ Paranoia	☐ Low self-esteem ☐ Academic/work problems ☐ Easily distracted ☐ Thinking same thought repeatedly ☐ Memory problems
INTERPERSONAL ☐ Increased conflict w/ others ☐ Increased family conflict ☐ Difficulty making/keeping friends	☐ Socially withdrawn/isolation ☐ Increased sexual problems/concerns ☐ Increased social anxiety ☐ Problems with intimacy	☐ Increased difficulty tolerating others ☐ Trouble with law/authority figures ☐ Intermittent relationships

TREATMENT QUESTIONAIRE

Have you had any previous **psychiatric hospitalizations?** Yes ☐ No ☐

Where	When	Reason

Have you had any previous **outpatient mental health treatment?** Yes ☐ No ☐

Where	When	Reason

Have you had any previous **prescribed psychiatric medications?** Yes ☐ No ☐

Medication	Prescribing Doctor	Dates

Have any family members had a history of **mental illness?** Yes ☐ No ☐

Persons	Diagnosis or Symptoms	Treatments

Have you ever experienced any **trauma**? Yes ☐ No ☐

If yes, have you been: ☐ Neglected ☐ Physically Abused ☐ Emotionally Abused ☐ Sexually Abused ☐ Don't Know

Any other incidents of **trauma**: ☐ Acts of War ☐ Witness/Victim of violence ☐ Serious Accidents ☐ Fire ☐ Other

Describe:

How are you **sleeping**? (Describe any recent changes or problems)

How is your **appetite**? (Include any recent weight changes)

What **leisure or stress reduction activities** do you use?

Past **interests/activities**:

Do symptoms interfere with your ability to work or get things done? Yes ☐ No ☐

Additional Comments/Information:

The above information is thorough and accurate to the best of my knowledge.

____ ____

Patient Signature (or Guardian) **Date**