Azure for Health & Human Services, LLC

REGISTRATION FORM

(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital

❑ Family/Friend	❑ Our Website	❑ Close to home/work	❑ Yellow Pages	❑ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance	❑ Aetna	❑ BC/BS	❑ Cenpatico	❑ Cigna	❑ UHC

❑ Humana	❑ Medicaid	❑ Medicare	❑ Tricare	❑ Other

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Azure for Health & Human Services, LLC or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

Treatment Consent Form

Explanation of Consent Form: This treatment consent form covers all procedures that are not of a nature to require a special consent, and it provides protection of the procedures performed by the behavioral health professionals at the Azure for Health and Human Services, LLC facilities. This form documents that the patient has consented to all services, including, but not limited to, psychological evaluation and medication management, allowing us to provide treatment to you. This form provides evidence that no guarantee is made by any professional at the Azure for Health and Human Services, LLC facilities concerning outcome of treatment. There is no guarantee that treatment will be successful. This form also provides evidence that consent is given only after a full explanation has been provided by doctors, therapists, and other staff at the Azure for Health and Human Services, LLC facility. If you have any questions concerning this or any other matter, it is your responsibility to check with your health care provider. By signing this form, you acknowledge that you understand your consent to treatment as explained in this form.

Consent to treatment: I, (Print Name) _____, for (Print Patient's Name) _____, do hereby voluntarily consent to care and treatment by Nabila Z. Haque, MD and her assistants and/or designees. I am aware that the practice of medicine, psychiatry, clinical social work, and other therapy by a licensed professional is not an exact science and I acknowledge that no guarantees have been made as to the result of evaluation or treatment.

I am aware that I am an active participant in the treatment process and that I share responsibility for such treatment. My responsibilities include informing the health care provider of any information that may be relevant to the problems or conditions being treated, assisting in setting goals for treatment, following therapeutic advice and prescribed medication to the best of my ability, and ending treatment in a responsible way. If I am consenting to treatment for another person, I certify that I am legally responsible for that person and am entitled to consent for them.

This form has been fully explained to me and I certify that I understand its contents. I also understand that it is my sole responsibility to ask any questions or obtain any clarification necessary to my understanding this form fully.

Signature of patient or legal guardian _____ Date _____

Printed name of patient _____ Printed name of legal guardian _____

Statement of Policy

The primary function of the service provided by Azure for Health and Human Services, LLC is clinically focused. Our service is geared towards providing quality medical treatment to our patients. Fulfilling the paperwork requirements for sick leave, long or short term disability, work capacity, or legal, custodial, and litigious determinations, all detract from time spent with patients. Moreover, Dr. Haque is of the opinion that such determinations should be rendered by an outside party rather that treating providers. To do otherwise may complicate the treating doctor-patient relationship, compromise the clinical management as a whole, and consequently contribute to a conflict of interest scenario. Therefore, this practice respectfully declines requests for paperwork. Exceptions ***might*** only be made for patients who have been treated for a period longer than 6 months.

_____ _____

(Patient or patient's guardian signature) (Date)

Notice of Privacy Practices Acknowledgement

I understand my health information is private and confidential. Azure for Health & Human Services, LLC will be continuing their effort to protect the privacy and confidentiality of my personal health information. I understand that Azure for Health & Human Services, LLC may use and disclose my personal health information to provide mental health care, to handle billing and payment, and to take care of other mental health operations. (There will be no other disclosures of this information unless I specifically authorize it in writing. I understand that rarely the law may require the release of my information without my authorization.) Azure for Health & Human Services, LLC has a detailed policy call the "Notice of Privacy Practices." It contains information about protecting my privacy. This "Notice of Privacy Practices" may be updated as needed and a copy will be available upon request. I will assist Azure for Health & Human Services, LLC by following office procedures (written request, reasonable time for completion and copying charges where indicated) if I choose to exercise any of my rights described in the "Notice of Privacy Practices." These rights include access, authorization for release of information, record of disclosure, and communication by the available method of my choice. My signature below indicates that I have read and understand a current of Azure for Health & Human Services, LLC "Notice of Privacy Procedures."

_____ _____ _____

(Patient or legally authorized signature) (Printed name) (Date of Birth)

_____ _____

(Relationship to patient if signed by anyone other than patient) (Today's date)

Patient Rights and Responsibilities

Patient Rights: Patients have the right to be treated with dignity and respect. Patients have the right to fair treatment, regardless of their race, religion, gender, ethnicity, age, disability or source of payment. Patients have the right to have their treatment and other member information kept private. Only when permitted by law, may records be released without permission. Patients have the right to easily access care in a timely fashion. Patients have the right to know about their treatment choices. This applies regardless of cost or coverage by the member's benefit plan. Patients have the right to share in developing their plan of care. Patients have the right to have a clear explanation of their condition and treatment options. Patients have the right to information about their insurance company, its practitioners, services, and role in the treatment process. Patients have the right to information about clinical guidelines used in providing and managing their care. Patients have the right to ask their provider about their work history and training. Patients have a right to know about advocacy and community groups and prevention services. Patients have a right to file freely a complaint or appeal and to learn how to do so. Patients have the right to know their rights and responsibilities in the treatment process. Patients have the rights to receive services that will not jeopardize their employment. Patients have the right to list certain preferences in a provider.

Patient Responsibilities: Patients have the responsibility to treat those giving them care with dignity and respect. Patients have the responsibility to give providers information they need. This is so providers can deliver the best possible care. Patients have the responsibility to ask questions about their care. This is to help them understand their care. Patients have the responsibility to follow the treatment plan. This plan of care is to be agreed upon by the member and provider. Patients have the responsibility to tell their provider and primary care physician about medication changes, including medications given to them by others. Patients have the responsibility to keep their appointments. Patients should call their providers as soon as they know they need to cancel visits. Patients have the responsibility to let their provider know when the treatment plan isn't working for them. Patients have the responsibility to let their providers know about problems with paying fees. Patients have the responsibility to report abuse and fraud. Patients have the responsibility to report openly concerns about the quality of care they receive.

My signature below shows that I have been informed of my rights and responsibilities and that I understand them.

_____ _____

(Patient or legal guardian signature) (Today's date)

Client Policies

Welcome to our practice. We look forward to serving as your behavioral health care professionals. In order for us to provide you with the best possible service, our practice policies are laid out below. Please take a few moments to read these policies carefully. Should you require any further clarification, the Azure staff would be pleased to answer any questions. A copy of this policy for your keeping is available upon request.

Appointments and Scheduling: Office visits are by appointment only and we encourage you to set an appointment while at your follow up visits to ensure you can be scheduled in a timely manner. General office hours are 9:30 AM to 5:00 PM, Monday through Saturday. ***An appointment means that time is reserved specifically for you. Forty-eight hours cancellation notice is expected or a missed appointment fee (not covered by insurance) of $45.00 will be charged for a missed appointment.***

Payment Policy: Payment is due at the time services are rendered. Payment can be made by cash, credit/debit card, or check. If a check is returned due to insufficient funds, you will be charged an additional fee of $15.00.

Non-covered Services: Some services are not covered by insurance, such as paper/forms, telephone consults with the doctor, or medical records. ***Forms, letters, and other such paperwork are charged at $20.00 per page. Telephone consults with the doctor are charged at $25.00 per 5 minute unit.*** Messages left for the doctor regarding side effects or other concerns are not considered "telephone consults". Requests to speak directly to the doctor or to have the doctor call you are considered "telephone consults". ***Medical record copies start at $15.00 for the first 25 pages, plus a per sheet charge of $0.15 thereafter.***

Emergencies: Should you need to alert the doctor to a potential side effect or allergic reaction or to schedule an urgent appointment, please contact the office at 678-799-9277. This is an outpatient behavioral health facility. As such, we are not equipped to respond to life-threatening emergencies. For a life-threatening emergency please call 911 or proceed to your nearest emergency room for immediate assistance. Please keep us informed of any such developments, both medical and mental health.

Medication Refills: Refills are made for patients under active treatment and who are keeping regular, scheduled appointments. You will be provided with a prescription at your appointment. Should a medication refill become necessary prior to your next scheduled appointment, please call 678-799-9277 ext. 2. ***Please do not wait until you are out of medications to take action. Refill requests made due to missed appointments will be charged at $25.00 payable at the time of request.*** Standards of care in the behavioral health field require that a stable patient must be seen ***at least*** once every three months***. No refills will be provided to a patient who has not been seen by their doctor for more than three months.***

Termination of Treatment: Patients have the right to discontinue treatment at any time. We encourage you to discuss and share your thoughts openly with the doctor. We also reserve the right to terminate treatment should the doctor conclude that he/she is unable to offer you the type or level or care that you require, should you be unwilling to adhere to the agreed upon treatment plan, or should you become noncompliant with the policies of this practice. Should termination of treatment become necessary, you will be notified so that you will have one month notice to make arrangements to seek another behavioral health care professional.

Weapons, Alcohol, and Tobacco Use: At no time and with no exception are weapons, alcohol use, or tobacco use permitted in any of the Azure for Health and Human Services, LLC premises.

I have read and understood the above listed Client Policies and accept these policies. I agree that I am responsible for all charges not covered by insurance for services rendered at time of service.

Patient Signature _____

Patient's Printed Name _____

Guardian's Signature _____

Date _____

Medications List

Please list below all current medications you are taking including “over the counter” medications such as vitamins.

Name of medication	Dosage	Frequency

Preferred Pharmacy Information: _____

Drug allergies: _____

Alcohol/Substance Usage

Substance	Never User	Frequency	Start Date: Year	End Date: Year
Tobacco				
Alcohol				
Sedatives/Benzodiazepines				
Hallucinogens/LSD				
Inhalants/glue, gas				
Stimulants/Amphetamines				
Cocaine/crack				
Painkillers (morphine, heroin, oxycontin, etc)				
Marijuana				
Steroids				
Other:				

ADULT HISTORY FORM **Patient name: _____** **Date: _____**

Please describe the current complaint or problem as specifically as you can, in your own words:

How long have you experienced this problem, or when did you first notice it?

What stressors may have contributed to the current complaint or problem?

CURRENT SYMPTOM CHECKLIST (Rate by circling the intensity of symptoms that are *currently* present)

0 = not present at this time
1 = present, bothers me a little, but not enough to be a problem
2 = present, bothers me and affects my quality of life, but still able to function
3 = moderate impact on quality of life and/or day-to-day functioning
4 = serious impact on quality of life and interferes with day-to-day functioning

Symptom	Severity	Symptom	Severity	Symptom	Severity
Depressed mood	0 1 2 3 4	Overeating/weight gain	0 1 2 3 4	Racing thoughts	0 1 2 3 4
Feelings of guilt, helplessness Or worthlessness	0 1 2 3 4	Excessive worrying or indecisiveness	0 1 2 3 4	Excessive energy	0 1 2 3 4
Difficulty concentrating	0 1 2 3 4	Feeling anxious/nervous	0 1 2 3 4	Overspending	0 1 2 3 4
Feeling irritable/restless	0 1 2 3 4	Panic attacks	0 1 2 3 4	Angry feelings	0 1 2 3 4
Insomnia	0 1 2 3 4	Sweaty palms	0 1 2 3 4	Angry behavior	0 1 2 3 4
Excessive sleeping	0 1 2 3 4	Mind going blank	0 1 2 3 4	Thoughts of hurting others	0 1 2 3 4
Forgetfulness	0 1 2 3 4	Heart racing	0 1 2 3 4	Temper outbursts	0 1 2 3 4
Loss of interest	0 1 2 3 4	Knot in stomach	0 1 2 3 4	Feel I'm being watched	0 1 2 3 4
Poor appetite/weight loss	0 1 2 3 4	Fear of places	0 1 2 3 4	Feel others are against me	0 1 2 3 4
Sadness/crying spells	0 1 2 3 4	Twitches, tics, or spasms	0 1 2 3 4	Hearing/seeing things	0 1 2 3 4
Tiredness/fatigue	0 1 2 3 4	Fear of places	0 1 2 3 4	Problem concentrating	0 1 2 3 4
Thoughts of hurting myself	0 1 2 3 4	Chest pain	0 1 2 3 4	Easily distracted	0 1 2 3 4
Thoughts of killing myself	0 1 2 3 4	Upset stomach	0 1 2 3 4	Problem completing tasks	0 1 2 3 4
Aches, pains, headaches	0 1 2 3 4	Lump in throat	0 1 2 3 4	Can't sit still	0 1 2 3 4

Have you ever been to a psychiatrist before? [ ] No [ ] Yes. If so, what diagnosis were you given?

Please indicate medications you have previously been prescribed for mental health:

[ ] Abilify
[ ] Adderall
[ ] Ambien/zolpidem
[ ] Atarax
[ ] Ativan
[ ] Buprenorphine/ Suboxone
[ ] Buspar
[ ] Celexa
[ ] Cymbalta
[ ] Depakote/ valproic acid
[ ] Dexedrine
[ ] Elavil
[ ] Effexor
[ ] Focalin
[ ] Geodon
[ ] Haldol
[ ] Hydroxyzine/ vistaril
[ ] Invega
[ ] Klonopin
[ ] Lamictal
[ ] Latuda
[ ] Lithium
[ ] Lunesta
[ ] Metadate
[ ] Methadone
[ ] Paxil
[ ] Pamelor
[ ] Prozac
[ ] Pristiq
[ ] Seroquel/ quetiapine
[ ] Restoril/ temazepam
[ ] Ritalin
[ ] Saphris
[ ] Strattera
[ ] Tegretol
[ ] Topamax
[ ] Viibryd
[ ] Vyvanse
[ ] Wellbutrin
[ ] Xanax
[ ] Zyprexa/ Olanzapine
[ ] Zoloft/Sertraline
[ ] Other, please list:

Which did you like most? Which did you like least?

Were you ever in the hospital for a psychiatric or substance abuse disorder? ____ No _____ Yes If so, please list the facility, time and reason of admission, and length of stay below:

Have you ever attempted to hurt yourself or commit suicide? ____ No _____ Yes If so, please explain:

Do you have access to any weapons? [ ] No [ ] Yes
Do you currently see a therapist or counselor? ____ No _____ Yes If so, who?
Alcohol or drug treatment history:
[ ] Outpatient [ ] Inpatient [ ] 12-step program [ ] Stopped on own

Family Psychiatric History: (check all that apply)

	Mother	Father	Sister	Brother	Aunt	Uncle	Children	Grandparents
Alcohol/drugs								
Anxiety								
Attention Deficit								
Bipolar Spectrum								
Depression								
Eating Disorder								
Posttraumatic stress								
Schizophrenia								
Suicide or suicide attempt								
Autism Spectrum								
Other:								

Personal Medical History: (Please check all that apply and list beside the category the details)

[ ] Anemia	[ ] Diabetes	[ ] Headaches	[ ] Irritable Bowel	[ ] Sleep Apnea	[ ] Hepatitis
[ ] Arthritis	[ ] Chronic Pain	[ ] Heart disease	[ ] GERD/Heartburn	[ ] Nerve damage	[ ] Stroke
[ ] Asthma	[ ] ENT	[ ] Head injury	[ ] Ulcers	[ ] Pancreatitis	[ ] Skin problems
[ ] Liver disease	[ ] Cancer	[ ] Brain tumor	[ ] Eye problems	[ ] GYN	[ ] HIV
[ ] High BP	[ ] Cholesterol	[ ] Kidney	[ ] Liver disease	[ ] Lung disease	[ ] Hysterectomy
[ ] Thyroid	[ ] UTI	[ ] Seizures	[ ] Neurological	[ ] Other:	

Please give further explanation or list other conditions if needed:

Occupational History: What is your current employment status?
[ ] Employed full-time [ ] Employed part-time [ ] Unemployed [ ] Self-employed
[ ] Student [ ] Other _____
Current occupation:
Are you satisfied with your employment? [ ] Yes [ ] No If not, why?

Marital History: Please check answer which best describes your current situation.
[ ] Never married [ ] Married (once) [ ] Married (multiple times) [ ] Divorced (once)
[ ] Divorced (multiple times) [ ] Separated [ ] Widowed [ ] Significant relationship
Educational History: Please check the answer which best describes your current situation.
[ ] Current student [ ] Some high school [ ] High school graduate [ ] Some college
[ ] Associate degree [ ] Bachelor degree [ ] Graduate degree [ ] Vocational training
Legal History:
Do you currently have any pending criminal charges? [ ] Yes [ ] No
Are you on probation? [ ] Yes [ ] No
Name of probation officer and county:
Have you ever been arrested/convicted of a crime? [ ] Yes [ ] No
If so, please list:

Trauma History:
Have you ever experienced emotional abuse? [ ] Yes [ ] No
Have you ever experienced physical abuse? [ ] Yes [ ] No
Have you ever experienced sexual abuse? [ ] Yes [ ] No
Have you ever experienced any other type of severe trauma? [ ] No [ ] Yes If so, please explain: