

Perspectives Therapy Services

Psychiatric Program

2200 Genoa Business Park Drive, Suite 100
Brighton, MI 48114
(810) 844-4093

Welcome.

We are honored that you have chosen *Perspectives Therapy Services* to accompany you on your personal journey of healing and wellness.

Before your first psychiatry appointment, please take some time to complete the attached intake packet. It is preferred that you bring these completed forms to our office in advance. Nonetheless, **all forms must be submitted by the time of your appointment.**

In addition to your forms, please also bring the following to your initial appointment:

- Complete list of ALL current prescription medications, supplements, and/or herbs you take, including dosages, frequencies, and reasons for taking them
- Copy of your latest blood work and/or laboratory results if any have been done within the past 12 months
- Copy of your health insurance card and state-issued ID

If you have any questions, please contact our psychiatric team at 810-844-4093.

Mental Health Intake Pt. I

Name: _____

Date of Appointment: _____ **D.O.B.** _____ **Age:** _____

Females

Pregnant? Yes: ___ No: _____

Menopause? Yes: _____ No: _____

If not pregnant and not past menopause, please indicate date of last period: _____

Medication or Environmental Allergies: Include names of medications and types of reactions (i.e. hives, difficulty breathing, etc.)

Current Medical Issues: (i.e. back pain, diabetes, thyroid, etc.)

Current Symptoms: Please place a checkmark (✓) to indicate any present symptoms, and a double checkmark (✓✓) for your **major** symptoms

- | | | |
|---|---|--|
| <input type="checkbox"/> Depressed mood | <input type="checkbox"/> Decreased need for sleep | <input type="checkbox"/> Restricting food and/or vomiting to lose weight |
| <input type="checkbox"/> Unable to enjoy activities | <input type="checkbox"/> Excessive energy | <input type="checkbox"/> Paranoia |
| <input type="checkbox"/> Sleep pattern disturbance | <input type="checkbox"/> Increased irritability | <input type="checkbox"/> Mood fluctuations |
| <input type="checkbox"/> Loss of interest | <input type="checkbox"/> Crying spells | <input type="checkbox"/> Hearing or seeing things that are not there |
| <input type="checkbox"/> Concentration/Forgetfulness | <input type="checkbox"/> Self-harm | <input type="checkbox"/> Excessive worry |
| <input type="checkbox"/> Change in appetite | <input type="checkbox"/> Thoughts of worthlessness | <input type="checkbox"/> Anxiety attacks |
| <input type="checkbox"/> Excessive guilt | <input type="checkbox"/> Thoughts of hopelessness | <input type="checkbox"/> Avoidance |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Sadness | <input type="checkbox"/> Hallucinations |
| <input type="checkbox"/> Decreased libido | <input type="checkbox"/> Distressing dreams or nightmares | <input type="checkbox"/> Suspiciousness |
| <input type="checkbox"/> Suicidal thoughts | <input type="checkbox"/> Repetitive actions (i.e. hand washing, checking doors, etc.) | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Thoughts of harming someone else | <input type="checkbox"/> Excessive nervous habits (i.e. skin picking, hair pulling, etc.) | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Racing thoughts | <input type="checkbox"/> Increased libido | |
| <input type="checkbox"/> Impulsivity | | |
| <input type="checkbox"/> Increased risky behavior | | |

Additional comments/explanations on above checked or additional symptoms not listed:

Past hospitalizations and/or outpatient/inpatient treatment for **mental health** reasons:

Previous mental health diagnosis:

Past hospitalizations for medical issues or surgeries:

When your mother was pregnant with you, were there any complications during the pregnancy or birth AND/OR any delays in development or issues in childhood (i.e. born prematurely, learning difficulties in school, etc.)?

Yes: ___ No: ___ If yes, explain:

Have you ever had a major head trauma where you lost consciousness or didn't know where you were at?

Yes: ___ No: ___ If yes, explain:

Exercise: Do you exercise regularly?

Yes: ___ No: ___ If yes, explain type, intensity, how long per session, and how many sessions per week:

Caffeine: How much caffeine do you consume in a typical day (including sodas, energy drinks, etc.)?

Tobacco:

Have you ever smoked cigarettes? Yes: ____ No: ____

Do you currently smoke cigarettes? Yes: ____ No: ____

If yes, how many packs per day, on average? _____ How long have you smoked? _____

If you used to smoke regularly, but have since quit, when did you quit? _____

Do you use non-cigarette nicotine or tobacco products (vaping, pipes, cigars, chewing tobacco, etc.)?

Yes: ____ No: ____ If yes, clarify: _____

Substance Use: Have you ever been treated for alcohol or drug abuse? Yes: ____ No: ____

If yes, for which substance(s)? _____

Where were you treated, and when? _____

Family Psychiatric History: Have **you** or **anyone in your family** ever been diagnosed with the following (If yes, indicate who)

- Bipolar Disorder _____
- Schizophrenia _____
- Depression _____
- Post-traumatic Stress _____
- Anxiety _____
- Obsessive-Compulsive Disorder _____
- Anger _____
- Alcohol Abuse _____
- Other substance abuse _____
- Suicide _____
- Violence _____

Has any family member been treated with a psychiatric medication? Yes: ____ No: ____

If yes, who was treated, what medications did they take, and how effective was treatment?

Family Background and Childhood History

Were you adopted? Yes: ____ No: ____

Where did you grow up? _____

List your siblings and their ages _____

What were your parents' occupations?

Did your parents divorce? Yes: ____ No: ____

If yes, how old were you when they divorced? _____

Who did you live with? _____

Describe your parents and your relationships to them:

How old were you when you left home? _____

Has anyone in your immediate family died? Yes: ____ No: ____

If yes, who and when? _____

How would you describe your childhood (i.e. loving, chaotic, difficult, traumatic, etc.)? Please explain:

Trauma History: Do you have a history of being abused emotionally, sexually, physically, or by neglect?

Yes: ____ No: ____ If yes, **when, where, and by who?**

Education History: What is your highest education level? (If applicable, please specify institution and degree)

Occupational History: Are you currently

Working: ____ Student: ____ Unemployed: ____ Disabled: ____ Retired: ____

If applicable,

What is/was your occupation? _____

Where do you work? _____

How long have you been at your present position? _____

Full time: _____ Part time: _____

Relationship History and Current Family: Are you currently

Married: ____ Partnered: ____ Divorced: ____ Single: ____ Widowed: ____

How long? _____

If not married or partnered, are you currently in a relationship?

Yes: ____ No: ____ If yes, for how long? _____

What is your significant other's occupation? _____

Describe your relationship _____

Have you had any prior marriages?

Yes: ____ No: ____ If yes, how long were you married? _____

Do you have any children?

Yes: ____ No: ____ If yes, how many? _____ List ages and genders: _____

Describe your relationship with your children:

List everyone who currently lives with you:

Legal History: Have you ever been arrested? Yes: ____ No: ____

Do you have any pending legal problems? Yes: ____ No: ____

Spirituality: Do you belong to a religion or spiritual group?

ANY ADDITIONAL INFORMATION:

Patient Name: _____ Signature: _____ Date: _____

Past Psychiatric Medications

If you have ever taken any of the following medications, please indicate the dates, dosages, and how helpful they were. If you can't remember all the details, just write in what you can remember.

Antidepressants	Dates	Dosage Response/Side Effects
Prozac (fluoxetine)	_____	_____
Zoloft (sertraline)	_____	_____
Luvox (fluvoxamine)	_____	_____
Paxil (paroxetine)	_____	_____
Celexa (citalopram)	_____	_____
Lexapro (escitalopram)	_____	_____
Effexor (venlafaxine)	_____	_____
Cymbalta (duloxetine)	_____	_____
Wellbutrin (bupropion)	_____	_____
Trintellix (vortioxetine)	_____	_____
Remeron (mirtazapine)	_____	_____
Anafranil (clomipramine)	_____	_____
Pamelor (nortriptyline)	_____	_____
Tofranil (imipramine)	_____	_____
Elavil (amitriptyline)	_____	_____
Other:	_____	_____

Mood Stabilizers	Dates	Dosage Response/Side Effects
Tegretol (carbamazepine)	_____	_____
Lithium	_____	_____
Depakote (valproate)	_____	_____
Lamictal (lamotrigine)	_____	_____
Tegretol (carbamazepine)	_____	_____
Topamax (topiramate)	_____	_____
Other:	_____	_____

Antipsychotics	Dates	Dosage Response/Side Effects
Seroquel (quetiapine)	_____	_____
Zyprexa (olanzapine)	_____	_____
Geodon (ziprasidone)	_____	_____
Abilify (aripiprazole)	_____	_____
Clozaril (clozapine)	_____	_____
Haldol (haloperidol)	_____	_____
Risperdal (risperidone)	_____	_____
Other:	_____	_____

Sleep Aids	Dates	Dosage Response/Side Effects
Melatonin	_____	_____
Over-the-counter meds (Tylenol PM, Zzz-Quil, etc.)	_____	_____
Ambien (zolpidem)	_____	_____
Sonata (zaleplon)	_____	_____
Rozerem (ramelteon)	_____	_____
Restoril (temazepam)	_____	_____
Desyrel (trazodone)	_____	_____
Other:	_____	_____

ADHD Medications	Dates	Dosage Response/Side Effects
Adderall (amphetamine)	_____	_____
Concerta (methylphenidate)	_____	_____
Ritalin (methylphenidate)	_____	_____
Vyvanse (lisdexamphetamine)	_____	_____
Strattera (atomoxetine)	_____	_____

Antianxiety Medications	Dates	Dosage Response/Side Effects
Xanax (alprazolam)	_____	_____
Ativan (lorazepam)	_____	_____
Klonopin (clonazepam)	_____	_____
Valium (diazepam)	_____	_____
Tranxene (clorazepate)	_____	_____
Buspar (buspirone)	_____	_____
Other:	_____	_____

Perspectives Therapy Services LLC

Disclosure Statement and Consent to Psychiatric Treatment

Provider Training and Credentials

Thank you for choosing *Perspectives Therapy Services LLC* (PTS) for your emotional, mental, relationship, and psychiatric needs. Your Perspectives provider has received an advanced degree in one or more of the following fields: marriage, family therapy, social work, professional counseling, or psychiatry. S/he is licensed through the state of Michigan. If s/he holds a limited license, or it is required by the particular insurance company, s/he will be supervised by a fully licensed clinician.

Therapeutically, our staff is trained to work with individuals, couples, and families. We comprise a group practice of independent private practitioners and are not affiliated with any medical center or hospital. **We are not available for emergency services** and advise that, in these cases, you contact your local Community Mental Health agency or your nearest medical center/hospital.

Psychiatry Specifics

The initial assessment meeting is charged at \$200.00. The out-of-pocket fee is \$150.00 for a psychiatric evaluation and \$90.00 for a medication review. Obligation for payment is understood not to be dependent upon the patient's receiving third-party reimbursement from insurance coverage. While the practice certainly supports and encourages patients to pursue the maximum amount of financial reimbursement from third-party payers—such as health insurance agencies—it is ultimately the patient's responsibility to ensure that s/he receives all third-party payments for which s/he may be eligible. PTS will submit all insurance billing for health insurance companies with which we are networked. All co-payments are due at the time of service. There is a returned check fee of \$20.00. It is our practice's policy to keep a credit card on file for all clients and patients in the practice. You may still choose to pay for your balances using another form of payment.

Session fees cover the following professional services:

- Psychiatric services
- Initial and ongoing assessments
- Treatment planning
- Time spent in consultation with other professionals

Phone contact—other than to schedule appointments or request prescription refills—is considered a consultation and may be billed at \$30.00 per 15 minutes. Report-writing is charged at a rate of \$150.00 per hour.

The providers at PTS do not provide custody evaluations or appear in court. Additionally, evaluations for disability applications are also not completed.

Patient Rights and Responsibilities

Although you may choose to end treatment at any time, you are responsible for attending any scheduled sessions. Unless a session is cancelled at least 24 hours prior to the time of the scheduled appointment, you will be responsible to remit payment of \$150.00 for a missed psychiatric evaluation session and \$90.00 for a missed medication review session. This is a strict policy with no exceptions. Please remember that if you are using insurance, charges cannot be submitted for missed sessions, and you will be held responsible for the charges as specified above. In cases of excessive absences, it will be at your provider's discretion to terminate services at PTS and possibly refer your care elsewhere. If a patient owes on their account, payment is expected during each visit in order to continue scheduling. If a balance exists whereby no payments have been made in 30 days, PTS will attempt to contact you. If no payments are made after these attempts, PTS contracts with an external collections service that will then pursue settling the amount due.

Information disclosed in session will be kept confidential and not revealed to any other person or agency without your written consent. However, there are exceptional circumstances that may require your therapist to share information obtained in a session without your permission. These exceptional situations include: (1) If you threaten serious bodily harm to yourself or another person, your provider is required by law to inform the intended victim and/or the appropriate law enforcement agency; (2) If your provider is subpoenaed by a court of law to provide specific information, s/he is obligated to comply; and (3) If you reveal information to your provider about child abuse and/or neglect, s/he is required by law to report this information to the appropriate authority.

After you have carefully read this information and have received satisfactory answers to any relevant questions, please sign this contract below. Anyone over the age of 18 years must sign this form in order to be treated through PTS. Parents or legal guardians must sign for persons under 18 years old.

I have read and understand the information provided in this document and agree to the outlined procedures and conditions. I understand that I may terminate treatment at any time and will be financially responsible for those sessions already completed.

Patient name (Print) _____ Date: _____

Patient signature (Parent signature for minor patients) _____ Date: _____

Provider signature _____ Date: _____

At times, there are persons who join the therapy process who are not identified as the “patient”, but are important to treatment. By signing below, you acknowledge this is a health care setting. The protections in place through our practice’s HIPAA policies protect you to the same degree as the primary patient. If a minor is joining the therapy process, the parent or legal guardian must consent to this participation by signing below:

Signature: _____ Date: _____

____ Initial here to acknowledge that you have read the Notice of Privacy Practices and that a copy of the Notice has been provided to you upon your request.

Expectations of Patients Receiving Psychiatric Care

Perspectives Therapy Services LLC (PTS) makes every effort to meet your mental health and medication needs. Please read the following expectations that our practice has of its psychiatric patients:

1. It is important that the patient keeps and attends all scheduled appointments with the provider. Consistent attendance and regular medical monitoring are imperative to comprehensive treatment.
2. It is essential that you take any prescribed medications as directed by your psychiatric care provider.
3. Women of childbearing age should avoid pregnancy while taking psychotropic medications. Women of childbearing age should notify their provider immediately if they intend to become pregnant or if there is a possibility, they may be pregnant.
4. It is our policy to coordinate care amongst the patient’s healthcare providers. This is especially true when medications are involved as they need to be monitored and assured that they can be safely used together. Once you sign a Release of Information form to permit inter-provider communication, we will coordinate with them on your behalf.
5. It is expected that you obtain any laboratory tests as requested by your psychiatric provider.
6. If you see a psychiatric care provider at PTS, it is expected that you will also be regularly seeing a therapist (preferably within the practice as well).
7. If, at any time, you and your provider decide to discontinue treatment, a 30-day supply of your medication can be prescribed to you. After that time, you are expected to contact your family physician for continuation of your medication regimen.
8. Patients who are seeing a psychiatric care provider because of disability are expected to bring disability forms to their scheduled appointments. In order to have your disability forms completed, you must keep all scheduled appointments.

If you have any questions about the psychiatric services you are receiving through PTS, please contact our psychiatric team at 810-844-4093.

Patient signature (Parent signature for minor patients) _____ Date: _____

Insurance Consent

By signing below, I give PTS permission to release all required information to my insurance company to attain payment for services rendered. I understand that if my insurance company does not cover these services, I am responsible for the balance.

Signature of Insured _____ Date: _____

Cell Phone Communication Consent

The patient and/or legal guardian of the patient has the privilege of contacting their provider via cell phone. This communication includes both phone calls as well as text messages. Know that this ability can be revoked if the provider deems the patient to be abusing this privilege. This definition of abuse is left to the discretion of the individual provider and may include, but is not limited to, excessive calls and texts from the patient and/or legal guardian despite the provider addressing the concern.

Please know that just because you call or text a provider does not mean you will receive an immediate response, or even a response at all. Some concerns brought up in a text message, for example, may be better addressed during a clinical session. Please note that the intention of receiving the provider’s phone number is primarily for scheduling purposes and to increase communicative efficiency. Please respect normal business hours when calling or texting your provider.

Providing this number **in no way** indicates 24-hour daily access to a provider’s services, nor should it be considered an emergency resource. If you or someone you know is in a mental health crisis, you are still instructed to contact your local Community Mental Health agency, call 911, or go to your local emergency room.

HIPAA Privacy Disclosure Regarding Cell Phone Communication

Please be advised that communication via cell phone is not secure. While all efforts will be made to maintain your privacy, the confidentiality of cell phone calls or text messages cannot be guaranteed.

By signing below, you are indicating that you understand and accept the above conditions. Failure to sign this section of the form will not change your care at PTS. It is completely optional.

Patient signature (Parent signature for minor patients) _____ Date: _____

Beck Anxiety Inventory

Below is a list of common symptoms of anxiety. Please carefully read each item in the list. Indicate how much you have been bothered by that symptom during the past month, including today, by circling the number in the corresponding space in the column next to each symptom.

	Not At All	Mildly but it didn't bother me much.	Moderately - it wasn't pleasant at times	Severely – it bothered me a lot
Numbness or tingling	0	1	2	3
Feeling hot	0	1	2	3
Wobbliness in legs	0	1	2	3
Unable to relax	0	1	2	3
Fear of worst happening	0	1	2	3
Dizzy or lightheaded	0	1	2	3
Heart pounding/racing	0	1	2	3
Unsteady	0	1	2	3
Terrified or afraid	0	1	2	3
Nervous	0	1	2	3
Feeling of choking	0	1	2	3
Hands trembling	0	1	2	3
Shaky / unsteady	0	1	2	3
Fear of losing control	0	1	2	3
Difficulty in breathing	0	1	2	3
Fear of dying	0	1	2	3
Scared	0	1	2	3
Indigestion	0	1	2	3
Faint / lightheaded	0	1	2	3
Face flushed	0	1	2	3
Hot/cold sweats	0	1	2	3
Column Sum				

Scoring - Sum each column. Then sum the column totals to achieve a grand score. Write that score here _____ .

Interpretation

A grand sum between **0 – 21** indicates very low anxiety. That is usually a good thing. However, it is possible that you might be unrealistic in either your assessment which would be denial or that you have learned to “mask” the symptoms commonly associated with anxiety. Too little “anxiety” could indicate that you are detached from yourself, others, or your environment.

A grand sum between **22 – 35** indicates moderate anxiety. Your body is trying to tell you something. Look for patterns as to when and why you experience the symptoms described above. For example, if it occurs prior to public speaking and your job requires a lot of presentations you may want to find ways to calm yourself before speaking or let others do some of the presentations. You may have some conflict issues that need to be resolved. Clearly, it is not “panic” time but you want to find ways to manage the stress you feel.

A grand sum that **exceeds 36** is a potential cause for concern. Again, look for patterns or times when you tend to feel the symptoms you have circled. Persistent and high anxiety is not a sign of personal weakness or failure. It is, however, something that needs to be proactively treated or there could be significant impacts to you mentally and physically. You may want to consult a physician or counselor if the feelings persist.

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?

(Use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + + +
=Total Score:

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all

Somewhat difficult

Very difficult

Extremely difficult

THE MOOD DISORDER QUESTIONNAIRE

Instructions: Please answer each question to the best of your ability.

	YES	NO
1. Has there ever been a period of time when you were not your usual self and...		
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	<input type="radio"/>	<input type="radio"/>
...you were so irritable that you shouted at people or started fights or arguments?	<input type="radio"/>	<input type="radio"/>
...you felt much more self-confident than usual?	<input type="radio"/>	<input type="radio"/>
...you got much less sleep than usual and found you didn't really miss it?	<input type="radio"/>	<input type="radio"/>
...you were much more talkative or spoke much faster than usual?	<input type="radio"/>	<input type="radio"/>
...thoughts raced through your head or you couldn't slow your mind down?	<input type="radio"/>	<input type="radio"/>
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	<input type="radio"/>	<input type="radio"/>
...you had much more energy than usual?	<input type="radio"/>	<input type="radio"/>
...you were much more active or did many more things than usual?	<input type="radio"/>	<input type="radio"/>
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	<input type="radio"/>	<input type="radio"/>
...you were much more interested in sex than usual?	<input type="radio"/>	<input type="radio"/>
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	<input type="radio"/>	<input type="radio"/>
...spending money got you or your family into trouble?	<input type="radio"/>	<input type="radio"/>
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	<input type="radio"/>	<input type="radio"/>
3. How much of a problem did any of these cause you – like being unable to work; having family, money or legal troubles; getting into arguments or fights? <i>Please circle one response only.</i>		
No Problem Minor Problem Moderate Problem Serious Problem		
4. Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	<input type="radio"/>	<input type="radio"/>
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	<input type="radio"/>	<input type="radio"/>

PSYCHIATRY REGISTRATION AND INTAKE FORM

PATIENT CONTACT INFORMATION

Last Name _____ First Name _____ Social Security # _____

Address _____ City _____ State _____ Zip _____

Please check below if a message can be left at the following numbers

____ Home phone: (____) _____ Work phone: (____) _____
____ Cell phone: (____) _____

Preferred Pharmacy name and phone: _____

Email address: _____

APPOINTMENT REMINDERS

Appointment information is considered to be "Protected Health Information" under HIPAA. By my signature, I am waiving my right to keep this information completely private and requesting that it be handled as I have requested below. Missed appointment fees will still apply if the reminder message is not received.

Where would you like to receive an appointment reminder? (check one)

- Via text message on my cell phone (Normal text message rates will apply according to your contract.)
 Via email message to the address listed above
 Via automated telephone message to my home phone
 None of the above: I'll remember my appointments on my own.

Signature: _____ Date: _____

PATIENT PROFILE INFORMATION

Date of Birth _____ Male _____ Female _____ Marital Status: Single _____ Married _____ Other _____

Household Member Name	Date of birth	Relationship to you
_____	_____	_____
_____	_____	_____
_____	_____	_____

Emergency contact: _____

Name	Phone number	Relationship
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BILLING INFORMATION

Responsible Party Name (Who pays the bill): _____ SSN: _____

Responsible Party Address: _____

Street	City	State	Zip Code
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Primary Insurance Company Name: _____

Subscriber/Member ID #: _____ Group #: _____

Patient relation to insured: Self _____ Spouse _____ Child _____ Other _____

Subscriber name: _____ Subscriber birthdate: _____

Secondary Insurance Company Name: _____

Subscriber/Member ID #: _____ Group #: _____

Patient relation to insured: Self _____ Spouse _____ Child _____ Other _____

Subscriber name: _____ Subscriber birthdate: _____

~ Perspectives Therapy Services, LLC ~

Medical Provider Coordination of Care
(Authorization to Disclose Protected Health Information)

Client name: _____ **DOB:** _____

In order to provide you with the highest quality care, we ask your permission to communicate with your primary care physician (PCP) or psychiatrist. This is also a requirement of most health insurance companies and therefore part of our compliancy contract with these payors.

Please read & check the appropriate box. If you do want information to go to your medical provider, then check the “YES” box and sign below. If you do not want information to go to your medical provider, then check the “NO” box and sign below.

Yes **No** I do hereby authorize/give my permission to exchange information with my medical provider listed below regarding my mental health treatment and medical healthcare for coordination of care purposes as may be necessary for the administration and provision of my healthcare coverage. The information exchanged may include information on mental health or substance abuse care and/or treatment such as diagnosis, estimated length of treatment, type of treatment to be provided and the treatment plan. I also understand that my therapist will provide my medical provider with periodic status reports of my progress during the course of treatment.

I further understand that the authorization shall remain in effect for one (1) year from the date of my signature or for the course of treatment, whichever is longer. I understand that I may revoke this authorization at any time by written notice to my therapist at Perspectives Therapy Services. I also understand that it is my responsibility to notify my therapist if I choose to change my medical provider.

Medical Provider name: _____ **Fax number:** _____

Practice name: _____ **Practice phone number:** _____

Practice address: _____

Psychiatrist name: _____ **Fax number:** _____

Practice name: _____ **Practice phone number:** _____

Practice address: _____

Client/Guardian Signature _____ **Date:** _____

Witness: _____ **Date:** _____

Credit Card Authorization

Perspectives Therapy Services LLC uses an integrated electronic medical record-keeping system for client charts and billing. This form serves as an authorization to input your credit card information into our secure system and charge it when a balance on your account exists.

The following are examples of charges that we would run on your credit card: co-payments, deductibles, document preparation/report-writing fees, costs for attendance at collaboration meetings, late cancel and no-show fees and returned check fees.

Should you choose not to pay for charges with a credit card, you may also pay using cash or check.

Type of Card (check one): MASTERCARD VISA
AMERICAN EXPRESS

Type of Card (circle one): CREDIT or DEBIT

Name of Cardholder: _____

Card No. _____

Expiration date: _____ Billing Zip Code: _____ CVV2 (security code): _____

Authorizing signature: _____ Date: _____

Client name (printed): _____

Provider(s) name: _____