Brick Psychiatric Services, Inc.
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2024 Update Form

Name: _____ **DOB:** ____/____/____ **Sex: M/F/**_____

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

Primary Phone: _____ **Alternative Phone:** _____

Email: _____

Emergency Contact: _____

Phone: _____ **Relationship:** _____

May we leave a detailed message with your emergency contact? Y / N
☐ ☐

Pharmacy Name: _____ **Pharmacy Phone:** _____

Pharmacy Address: _____

Please attach front and back of insurance cards or fill out below.

Primary Insurance Company: _____
Insurance ID: _____
Group ID #: _____
Billing Address (back of card): _____
Behavioral Health/Mental Health Services Phone #: _____
Policy Holder: _____ **Date of Birth:** _____/ _____ / _____
Policy Holder Address: _____

Secondary Insurance Company: _____
Insurance ID: _____
Group ID #: _____
Billing Address (back of card): _____
Behavioral Health/Mental Health Services Phone #: _____
Policy Holder: _____ **Date of Birth:** _____/ _____ / _____
Policy Holder Address: _____

Brick Psychiatric Services, Inc.

Recent blood pressure? _____ **Weight:** _____ **Height:** _____

Allergies? ☐ **No** _____

Recent hospitalizations? ☐ **No** _____

Vaccinations:

Have you been vaccinated for the Influenza virus within the past year? ☐ **Yes** ☐ **No**

Have you been vaccinated for Pneumonia within the past five years? ☐ **Yes** ☐ **No**

Have you been vaccinated for COVID-19? ☐ **Yes** ☐ **No**

Have you received any COVID-19 booster vaccinations? ☐ **Yes** ☐ **No**

Have you received the RSV vaccination within the past two years? ☐ **Yes** ☐ **No**

Social History:

Do you drink alcohol? ☐ **Yes** ☐ **No** **If yes, how often:** _____

Do you have a history of smoking? ☐ **Yes** ☐ **No** **If yes, do you presently smoke?** ☐ **Yes** ☐ **No**

How many packs? Per day ____ **Per week** ___ **Do you vape?** ☐ **Yes** ☐ **No**

Do you have a history of:

- ☐ **drug abuse?**
- ☐ **suicidal behavior?**
- ☐ **inpatient psychiatric treatment?**
- ☐ **assaultive behavior?**
- ☐ **falls?**

If you answered yes to any of the above, please explain in detail: _____

_____

_____

Brick Psychiatric Services, Inc.
HIPAA Authorization

HIPAA: Patient Restriction of Disclosures

The HIPAA privacy rule gives you, the patient, the right to request a restriction on uses and disclosures of your protected health information. Please carefully complete the following statement by initialing all options that apply:

I may be contacted in the following manner:

Cell Phone	**Work Phone**	**Home Phone**	**Written**
☐ Detailed Message	☐ Detailed	☐ Detailed	☐ Detailed
☐ Limited Message	☐ Limited	☐ Limited	☐ Limited

Best Contact Number: _____

HIPAA: Patient Designation of Disclosures

The HIPAA privacy rule gives you, the patient, the right to designate a person or persons to act on your behalf. Please carefully complete the following statement:

CHECK ONE OF THE BELOW STATEMENTS

_____☐ I hereby allow the following person(s) to be given information regarding my treatment. This information may be given solely to the people listed below through verbal communication, written communication, or in person.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____☐ I do not wish for anyone to be able to obtain information regarding my treatment.

I certify that I have read (or have read to me) the above statement and fully understand the content.

_____ _____

Signature of Patient / Parent / Guardian **Date**

Brick Psychiatric Services, Inc.

Financial Policy

I hereby agree that Brick Psychiatric Services is authorized to bill and receive payment from my insurance company and for services rendered to me or my family. Brick Psychiatric Services may release only the appropriate information required by said companies for the payment of claims submitted. Please note patient privacy policies located in the waiting room. This consent is valid continually until revoked in writing.

Filling insurance is NOT a guarantee of payment. Brick Psychiatric Services will bill my insurance company (if participating). If my insurance company denies payment for any reason, I understand that I will be responsible for the assigned fee.

A 24 HOUR NOTICE IS REQUIRED FOR ALL APPOINTMENT CANCELLATIONS. FAILURE TO DO SO WILL RESULT IN A $50 FEE, WHICH IS THE SOLE RESPONSIBILITY OF THE PATIENT.

We require payment in full, which is due at the time of service unless we participate with your insurance company or prior arrangements have been made. **You are ultimately responsible for payment and knowing what is or is not covered by your insurance policies.** If you have an HMO, you are also responsible for confirming that we have authorization to see you prior to all of your appointments. We will file claims to insurance companies with which we have a contract. We will file claims with non-participating and secondary insurance companies as well. However, payment for all services will revert back to the patient if non-contractual insurance payments are not made to this office within 30 days of the claim being filed. We collect all copayments, co-insurance, and deductibles at the time of services. In the event of a virtual appointment, payments must be made 2 days prior to the scheduled appointment.

We accept cash, credit and debit cards. We do NOT accept checks.

MISSED APPOINTMENTS: You may be subject to a $50 charge for missed appointments if appointments are not cancelled at least 24 hours in advance. NO APPOINTMENTS WILL BE MADE UNTIL ALL FEES AND/OR BALANCES ARE PAID.

FINANCIAL AGREEMENT: The undersigned agrees that in consideration of the services to be rendered to the patient, he/she must hereby individually obligate himself/herself to pay the account of the physician in accordance with the regular rates and terms of the mental healthcare professional. Should the account be referred to an attorney for collection, the undersigned shall pay all the attorney fees and all collection expenses.

_____ _____

Signature of Patient / Parent / Guardian **Date**

Patient Health Questionnaire (PHQ-9)

Name: _____ Date: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?	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: Total Score _____ = _____ + _____ + _____

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