GEORGE M. NORTHRUP, M.D., P.A.

GENERAL PSYCHIATRY- FORENSIC PSYCHIATRY

NEW PATIENT INSURANCE VERIFICATION AND AUTHORIZATION

Date: _____ Referred By: _____

Patient Name: _____ DOB: _____
Home Address: _____ Apt/ Unit #_____
(City, State, Zip) _____
Cell Phone #: (___) ____-_____
Email:_____
Social Security #: _____-_____-_____
Employer Name: _____ Work Phone #: (___) ___- _____

Primary Insurance Company: _____
Insurance Provider #: (_____) _____-_____
Member Id #: _____ Group #: _____
Name of Insured: _____
Insured's DOB: _____ Insured's SS#: _____
Relationship to Patient: _____

Secondary Insurance Company: _____
Insurance Provider #: (_____) _____-_____
Member Id #: _____ Group #: _____
Name of Insured: _____
Insured's DOB: _____ Insured's SS#: _____
Relationship to Patient: _____

Authorization Required: ☐ **Yes** ☐ **No** ☐ **Unknown**
If yes, Authorization #: _____

In case of emergency you have my permission to contact:
Name _____Phone #: _____
Relationship to patient: _____

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Receipt of Notice of Privacy Practices Form

I, _____ hereby acknowledge receipt of George M Northrup M.D P.A Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

I understand that George M Northrup M.D., P.A. has reserved the right to change their privacy practices that are described in the Notice. I also understand that the copy of any Revised Notice will be provided to me or made available.

Signed: _____ Date: _____

If you are not the patient, please specify your relationship to the patient: _____

HIPAA Communication Profile

To ensure compliance with HIPAA guidelines, please provide us with the following information to establish and confirm your preference for future communication with our office.

Where do you prefer to be called? ***Enter your order of preference (1 through 4) below***. Leave the space blank if you do not wish to be called at a particular location.

☐ Primary Phone ☐ Work Phone ☐ Cell Phone ☐ Email _____

Voice Mail:

Please place a check mark next to those voicemails where we can leave you a confidential message. Leave the space blank if you do not wish to receive voicemails or if you do not have voicemail.

☐ Myself Only ☐ My Spouse ☐ My Parent ☐ Other

Protected Healthcare Information Designees:

Please place a check mark next to those individuals with whom we may discuss your protected health care information, either per your specific instructions or in situations where you are not available.

☐ Myself Only ☐ My Spouse ☐ My Parent ☐ Other

_____ _____

Other Designee Relationship

You may change your selections at any time but must do so in writing by completing an updated form.

_____ _____

Signature Date

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GENERAL PSYCHIATRY- FORENSIC PSYCHIATRY

Primary Care Information:

Provider's Name: _____
Telephone #: (_____) _____-_____
Provider Email: _____(if available)

Therapist/ Counselor/ LCSW:

Provider's Name: _____
Telephone #: (_____) _____-_____
Provider Email: _____(if available)

Specialist (OB / GYN)

Provider's Name: _____
Telephone #: (_____) _____-_____
Provider Email: _____(if available)

Other Specialist

Provider's Name: _____
Telephone #: (_____) _____-_____
Provider Email: _____(if available)

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MEDICATION LIST

PATIENT NAME: _____ DOB: _____

CURRENT MEDICATION	DOSAGE	REASON FOR MEDICATION

IN	DATE	MEDICATION	MG	DIRECTIONS	#	RF

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GENERAL PSYCHIATRY- FORENSIC PSYCHIATRY

New Patient Questionnaire

Name: _____ Date:_____

DOB: _____ Age: _____ Height: _____ Weight: _____

Sexual Orientation:(Check)

☐ **Heterosexual** ☐ **Homosexual/Lesbian** ☐ **Bisexual** ☐ **Transsexual**

Marital Status:

☐ **Single** ☐ **Married** ☐ **Separated** ☐ **Divorced** ☐ **Widowed** ☐**Domestic Partner**

Living Situation (e.g. own/rent, who is in household):

_____

Allergies:_____

What brings you in today?

What are your current biggest stresses?

General- (check all that apply)

☐ **Not getting along with other people**
☐ **Not fitting in with peers**
☐ **Being shy**
☐ **Being uncomfortable when talking to people**
☐ **Feeling uncomfortable in social settings**
☐ **Acting rude or overbearing**
☐ **Being suspicious of others**
☐ **Not having closing friends**
☐ **Feeling lonely**
☐ **Feeling like people are against me**

☐ **Feeling anxious or uptight**
☐ **Being afraid of things**
☐ **Not being able to stop worrying**
☐ **Not being able to relax**
☐ **Feeling restless/ tense**
☐ **Having been traumatized**
☐ **Having nightmares**
☐ **Having flashbacks**
☐ **Avoiding people, places, or things**

☐ **Being overweight**
☐ **Having physical handicap**
☐ **Having unattractive face**
☐ **Being noticed for physical appearance**

☐ **Other problems with appearance: _____**

☐ **Being afraid of failing on the job**
☐ **Boss being critical or unfair**
☐ **Working too many hours**
☐ **Children misbehaving**
☐ **Disagreeing on how to raise children**
☐ **Child or partner having medical problem**
☐ **Job having no future**
☐ **Being bored on the job**
☐ **Job creating health problems**
☐ **Partner Being unfaithful**
☐ **Having sexual problems in relationship**
☐ **Being unfaithful to partner**

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GENERAL PSYCHIATRY- FORENSIC PSYCHIATRY

- ☐ Child or partner having emotional problem
- ☐ Partner having problem with drug or alcohol
- ☐ Other regarding spouse, children, or In-laws _____
- ☐ Budgeting money
- ☐ Not making enough money
- ☐ Not having a steady income
- ☐ Having unpaid bills
- ☐ Having problems with sexual relationship
- ☐ Disliking sex
- ☐ Spouse working too many hours
- ☐ Arguing with Partner over money
- ☐ Wasting money
- ☐ Spouse being careless with money
- ☐ Having to spend savings
- ☐ Worry about diseases or illness
- ☐ Being troubled by sexual attitudes of others
- ☐ Being troubled by unusual sexual behavior

Do you have any odd or unusual habits? (explain)

Do you have any habits that bother other people? (explain)

Is there a history for any of the following?

Yourself?		A blood relative
☐	Depression	☐
☐	Anxiety	☐
☐	Substance Abuse	☐
☐	Psych. Hospitalization	☐
☐	Legal Problems	☐
☐	Suicide Attempts	☐

Any Hospitalizations? Please explain:

I was raised by _____. I have____ siblings. (___Brothers ___ Sisters)

Describe your maternal figure in 3 words_____

Describe your paternal figure in 3 words _____

Describe your childhood in 3 words _____

Past Hospitalizations/Surgical History and Date

Hospitalizations/ Surgery

YEAR	WHERE	NATURE OF ILLNESS

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Social

Is there a history of the following?

Yourself		Blood Relative
☐	High Blood Pressure	☐
☐	Diabetes	☐
☐	Stroke	☐
☐	Heart Attack	☐
☐	Thyroid Problem	☐
☐	Liver Problem	☐
☐	Kidney Problem	☐
☐	Alzheimer's	☐
☐	Cancer:	☐

_____ Type _____

Highest Level of Education: _____

Military History: ☐ Yes ☐ No

If yes, please give details of years active

Occupation: _____

Check all that Apply:

☐ Tobacco ☐ Past ☐ Current Avg # of packs/day _____ for # of years _____

☐ Alcohol ☐ Past ☐ Current Avg # of drinks/ week_____ for # of years_____

☐ Cocaine ☐ Past ☐ Current Avg use/week _____ for # of years _____

☐ Marijuana ☐ Past ☐ Current Avg use/week _____ for # of years _____

☐ Speed/Amph ☐ Past ☐ Current Avg use/week _____ for # of years _____

☐ Hallucinogens ☐ Past ☐ Current # of trips lifetime_____

☐ Other ☐ Past ☐ Current Substance_____ Details of Use:

Have you ever had any of the following?

	YES	NO
Significant Weight gain? (___lbs.)	☐	☐
Significant Weight loss? (___lbs.)	☐	☐
Weakness in arms or legs?	☐	☐
Headaches which are chronic or severe?	☐	☐
Difficulty walking?	☐	☐
Loss of consciousness?	☐	☐
Problems with vision other than needing glasses?	☐	☐
Change in hearing?	☐	☐
Dizziness?	☐	☐
Daily Cough?	☐	☐

GEORGE M. NORTHRUP, M.D., P.A.

GENERAL PSYCHIATRY- FORENSIC PSYCHIATRY

Shortness of breath?	☐	☐
Discomfort in chest?	☐	☐
Frequent swelling in ankles?	☐	☐
Pain in legs while standing?	☐	☐
High blood pressure?	☐	☐
Severe abdominal pain?	☐	☐
Frequent heartburn or indigestion?	☐	☐
Tar- colored or bloody bowel movements?	☐	☐
Do you lose control of stool at times?	☐	☐
Bloody or unusual appearing urine?	☐	☐
Do you lose control of urine at times?	☐	☐
Frequent awakening at night?	☐	☐
Any skin problems?	☐	☐
Neck pain or stiffness?	☐	☐
Back pain or injury?	☐	☐
Sexual Problems?	☐	☐

Is there anything else you would like to add which you have not already?

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GENERAL PSYCHIATRY- FORENSIC PSYCHIATRY

Social Security, Short/Long-Term Disability or FMLA Evaluations

complete the following:

Reason for leave/ symptoms?

Referring Primary Care Physician Name: _____

Phone #: _____

Date of onset of symptoms: _____ **Date of last day worked:** _____

Nurse Case Manager Name: _____

Phone #: _____

Has this request been denied by another physician within the last 30 days? ☐ **Y** ☐ **N**

If yes, what was reason for denial: _____

I understand and agree to pay for charges incurred to complete paperwork associated with an evaluation or claim. I acknowledge the forms will only be submitted after payment for such documents has been received and applied to account. Completion of forms does not guarantee approval of your claim/request. Final considerations are determined by employer/carrier.

_____ _____

Signature **Date**

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GENERAL PSYCHIATRY- FORENSIC PSYCHIATRY

PATIENT ACKNOWLEDGEMENT

Please read and initial each line

_____ **Remembering the date and time of my scheduled appointment is MY responsibility. Reminder calls are a courtesy and do not negate my responsibility to my session. I agree to provide the office a minimum of 24 business hours' notice if I need to cancel/reschedule my appointment.**

We do our best to stay on schedule therefore we do not overbook appointments. Missing appointments or arriving late not only disrupts the flow of the schedule, but also is not fair to other scheduled patients or to those who may need to be seen on an urgent basis.

_____ **I understand that I will be billed $85.00 for ANY appointment I fail to keep or cancel without a 24 hours' notice.**

_____ **I may reduce my no show/ late cancellation fee to $50 by having an active credit card on file. I give my permission to keep the following information on file:**

(Check one): ☐ **VISA** ☐ **Mastercard** ☐ **Discover**

_____ **EXP Date:** _____ **CVV:** _____

I understand my card will be processed in the event of the aforementioned. I understand I will receive written notification from the office if my card is charged.

_____ **My portion of payment for services is due at the time services are rendered.**

_____ **I understand if my account is turned over to a collection agency for non-payment, I will be responsible for the collection agency fee as well.**

_____ **Requests for letters and forms to include disability forms will constitute an additional charge based on the necessary time required for their completion. A minimum of (5) business days are required for completion.**

_____ **There will be a $20 charge for Medication prior or continuing authorizations.**

_____ **This physician's office has a relationship with ME, not my insurance company. The office will bill my insurance promptly but if the insurance company does not pay after 60 days, I will be billed for the total outstanding balance.**

_____ **I authorize use of my information, including my diagnosis, to all my Insurance Companies. I authorize this office to act as my agent in helping me obtain payment for services. I authorize payment be made directly to the office. *If you prefer your information not be disclosed. Please ask to speak to a member of the staff.**

_____ **Although in some cases prescription request will be handled on the same day, I will give this office a minimum of THREE (3) business day notice when requesting a medication refill or new prescription.**

_____ **Prescription refills will NOT be completed during evenings, weekends, or holiday hours.**

My signature indicates that I have read and understand, and I agree to comply with this Two (2) page agreement.

_____ _____

Signature Date

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Notice of Privacy Practice

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We care about our patients' privacy and strive to protect the confidentiality of your medical information at this practice. New federal legislation requires that we issue this office Notice of our privacy practices. You have the right to the confidentiality of your medical information, and this practice is required by law to maintain the privacy of that protected health information. This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have any questions about this Notice, please contact the Privacy Officer at this practice.

Privacy Officer: Brittannie Woll, Clinic Administrator Effective: March 1, 2012

Who Will Follow This Notice

Any health care professional authorized to enter information into your medical record, all employees, staff, and other personnel at the practice who may need access to your information must abide by this Notice. All subsidiaries, business associates, sites, and locations of this practice may share medical information with each other for the treatment purposes or health care operations described in this Notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be shared.

How We May Use and Disclose Medical Information About You

The following categories describe different ways that we may use and disclose medical information without specific consent or authorization. Examples are provided for each category of uses or disclosures. Not ever possible use or disclosures in a category is listed.

For Treatment. We may use medical information about you to provide you with medical treatment services. Example: In treating you for a specific condition, we may need to know if you have any allergies that could influence which medication, we prescribe for the treatment process.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive from us may be billed and payment may be collected from you, an insurance company or a third party. Example: We may need to send your protected health information, such as your name, address, office visit date, and codes identifying your diagnosis and treatment to your insurance company for payment.

For Health Care Operations. We may use and disclose medical information about you for health care operations to assure that you receive quality care. Example: We may use your medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

Other Uses or Disclosure That Can Be Made Without Your Consent or Authorization

- As required during an investigation by law enforcement agencies
- To advert a serious threat to public health or safety
- As required by military command authorities for their medical records
- To workers' compensation or similar programs for processing of claims
- In response to a legal proceeding
- To a coroner or medical examiner for identification of a body
- If an inmate, to the correctional institution or law enforcement official
- As required by the US Food and Drug Administration (FDA)

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Uses and Disclosures of Protected Health Information Requiring Written Authorization

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you give us permission to use or disclose medical information about you, you may revoke that permission, in writing, at the time. If you revoke your permission, we will thereafter no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain records of the care we have provided you.

Your Individual Rights Regarding Your Medical Information

Complaints. If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer at this practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized or discriminated against for filing a complaint.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations or to someone who is involved in your care or the payment for your care. We are not required to agree to your request. If we do agree, we will comply with

your request unless the information is needed to provide you with emergency treatment. To request restrictions, you must submit your request in writing to the Privacy Officer at this practice. In your request, you must tell us what information you want to limit and where in your records this information is contained.

Right to Request Confidential Communications. You have the right to request how we should send communications to you about medical matters, and where you would like those communications sent. To request confidential communications, you must make your request in writing to the Privacy Officer at this practice. We will not ask you the reason for your request. We will accommodate all reasonable requests but reserve the right to charge you a cost-based fee for any non-customary expenses involved. Your request must specify how or where you wish to be contacted.

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records but does not include psychotherapy notes, information compiled for use in a civil, criminal, or administrative action or proceeding, and protected health information to which access is prohibited by law. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer at this practice. If you request a copy of the information, we reserve the right to charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect an certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by this practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend. If you feel that medical information, we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at this practice. In addition, you must provide a reason to support the request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request. If the information was not created by us, is not part of the medical information kept at this practice, is not part of the information which you would be permitted to inspect and copy, or which we deem to be accurate and complete. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Statements of disagreement and any corresponding rebuttals will be kept on file and sent out with any future authorized request for information pertaining to the appropriate portion of your record.

Right to an Accounting of Non-Standard Disclosures. You have the right to request a list of the disclosure we made of medical information about you. To request this list, you must submit your request in writing to the Privacy Officer at this practice. Your request must state the time for which you to receive a list of disclosures that is no longer that six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (example: on paper or electronically). The first list you request in writing within a 12-month period will be free. For additional lists, we reserve the right to charge you for the cost of providing the list.

Right to a Paper Copy of This Notice. You have the right to a paper copy of the Notice of Privacy Practices at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy. To obtain a paper copy of the current Notice, please request one in writing from the Privacy Officer at this practice.

Change to This Notice. We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice for medical information we already have about you as well as any information we receive in the future. We will post the current Notice, with the effective date in the upper right corner.