4424 Montgomery Ave
Suite 201
Bethesda, MD 20814

(888)715-1120 (office)
(888)715-1130 (fax)
healthyfoundationsgroup.com

Name of Patient____

Welcome to Healthy Foundations Group. We hope that the time you spend here is both pleasant and productive. We would like to take this opportunity to inform you of several office policies.

PAYMENT

Patients are expected to pay in full at the time of service unless prior financial arrangements have been made. Please include the complete name of the patient if paying by check. This group does not participate in any insurance plans. However, we collect insurance information to complete administrative processes as needed. Your statement will include all of the information necessary for insurance claims. We suggest that you submit the claim as soon as you receive the statement and keep a copy for your records.

*****The patient or responsible person is ultimately accountable for all fees due.**

CANCELLATION AND MISSED APPOINTMENTS

Unless notice of cancellation is given two business days (M-F, 9AM-5PM) before the date and time of the appointment, patients will be billed the full fee for the appointment. This policy applies to all patients.

****Please note, insurance does not cover the charge for missed appointments.**

PRESCRIPTION REFILLS

For patients on medication, if you will not be seen before running out of medication, please allow at least two business days for a prescription refill. You may have your pharmacy notify this office, or call in with your request. If calling yourself, please be sure to state the full name of the patient, date of birth, medication name, dosage, frequency and pharmacy telephone number in your message.

****DEA Schedule II Controlled Substances (i.e. medications for ADHD) refills require an office visit. You are responsible for ensuring you have enough medication to last until your next visit. Per DEA guidelines, no refills will be provided without an office visit.**

CORRESPONDENCE

To both protect your privacy and facilitate communication, we ask that you sign up for the patient portal, as it will allow you to send secure messages to your clinician. Although every effort will be made to protect confidentiality, e-mail/text is not secure and this office cannot ensure the protection of personal information communicated using these means. Should you send communication via email/text, you authorize us to provide a like kind response via the same method.

****Clinical/urgent/emergent information should not be communicated via email/text.**

URGENT MATTERS & EMERCENCIES

In the event of an urgent, but non-emergent matter, we can be reached via the main office line provider/emergency option. In the event of an emergency, please call 911 or proceed to your nearest emergency room. Once stable, please contact this office to notify us of the event.

I agree to the above office policies.

_______________________________ _______________________________

Signature & Date Name (please print)

Patient Information

Patient Name: ____

Age: _____ Date of Birth: ______________ Sex Assigned at Birth: _____________ Gender: _______________

Employment Status: ________________________ School/Employer: _________________________________

Address: ____

City: ______________________________ State: ______________ Zip: _________________

Home Phone: _________________________ Cell: ________________________ Work: __________________

Is it okay to leave a message? Y/N If so, it is okay to identify the clinician/clinic in a message? Y/N

Email: ____ Is it okay to send an email? Y/N

Legal Guardian (if applicable)

Name/Relationship: ____

Address: ____

City: ______________________________ State: ______________ Zip: _________________

Home Phone: _________________________ Cell: ________________________ Work: __________________

Is it okay to leave a message? Y/N If so, it is okay to identify the clinician/clinic in a message? Y/N

Email: ____ Is it okay to send an email? Y/N

Pharmacy Info

Pharmacy: ____ Telephone number: _______________________

Person Responsible for Payment

☐ Same As Patient ☐ Same As Legal Guardian

Name: ____

Relationship to Patient: ________________________

Address: ____

City: ______________________________ State:_______________ Zip: _________________

Home Phone: ________________________ Cell: ______________________ Work: _____________________

Referred by: ____

Credit Card Authorization Form

Today's date: __________ Patient Name: __________________________________

The card will be charged in accordance with our cancellation policy.

Credit Card Information:

Name as it appears on the Card:

____

Street: ____

City: _________________________________State:________________ Zip: _________________

Telephone: ___________________________

Email Address For Receipts: ____

Type of Card: □VISA □MASTERCARD □DISCOVER □AMERICAN EXPRESS

Credit Card Number: ___________________________________

Expiration Date: ____/____

Security Code (3 digits/4 digits for AmEx): ____________________

I hereby authorize this card to be used for payment of services rendered and or/no show cancellation fees.

Please sign for future authorization:

____

This Authorization can be faxed to 888-715-1130 or e-mailed to billing@healthyfoundationsgroup.com.

Authorization to Release/Disclose Protected Health Information

** Please provide to the names and phone numbers of all individuals, clinics, or hospitals where previous or ongoing treatment has taken place.

Patient Name: __________________________________ Date of Birth: _____________
Phone: _____________________

I hereby authorize the exchange of my heath/mental health information between Healthy Foundations Group and the following individual (s) and/or organizations (s):

Primary Care Doctor: ____
Phone: ____

Emergency Contact: ____
Phone: ____

Current and/or Previous Psychiatrists: ____
Phone: ____

Current and/or Previous therapists: ____
Phone: ____

Name of person/provider/facility: ____
Phone: ____

This authorization has no expiration date, except it shall automatically expire upon a minor's 18th birthday. These records/information are for services provided at the facilities indicated. The information may be used/disclosed for treatment purposes both at the time of disclosure and at any time in the future unless otherwise indicated here: ___________.

I understand that after my the custodian of records discloses my mental health information, the law prohibits the recipient from re-disclosing this information without my authorization. I understand, however, that if my mental health information is disclosed to a recipient who is not covered by federal medical privacy regulations; the information may be re-disclosed without penalty under these federal regulations.

I understand that I have the right to meet with my clinician to inspect my records of mental health information. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment, receive payment, or eligibility for benefits unless allowed by law. I understand that I have the right to revoke this authorization by sending written revocation to the custodian of records/information named above, as well as to the recipient(s) named above. I further understand that my revocation will be effective upon receipt, except if this release has already been relied upon.

By signing below I, represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

________________________________ ________________________________
Signature & Date Name (please print)

History Questionnaire

Please complete this form prior to the first appointment. If you require additional space, please use the back of the page.

Please state the reason that you are seeking a psychiatric evaluation. What is the problem(s)? When did it begin? What has been done to try to alleviate the problem(s)?

Past Mental Health History

Current and/or previous psychiatrists (please include telephone numbers):

____
____

Current and/or previous therapists (please include telephone numbers):

____
____

Previous Diagnoses:

____
____

Previous Psychiatric/Psychological testing (please include clinician and date of testing):

____
____

Intensive Outpatient Programs/Partial Hospitalization Programs (please include locations and dates):

____
____

Psychiatric Hospitalizations (please include locations and dates):

____
____

Self Harm/Suicide Attempts (please describe):

____
____

Any history of aggression/violence (please describe):

____
____

Substance Use History:

Do you use alcohol? If yes, please describe (i.e. frequency, quantity, etc.):

____
____

Do you use tobacco? If yes, please describe (i.e. type – cigarettes vs. chewing, frequency, number of packs per day, etc.)

____
____

Do you use marijuana? If yes, please describe (i.e. type, frequency, quantity, etc.):

____
____

Do you use illicit drugs? If yes, please describe (i.e. drug, frequency, quantity, etc.):

____
____

Do you abuse any prescribed medications: If yes, please describe (i.e. drug, frequency, quantity, etc.):
____
____

Medical History

Primary Care Physician: ____
Telephone number: _______________________________ Date of last physical exam: _______________

Are you pregnant? Y/N If yes, are you receiving any pre-natal care? Y/N
Are you currently in any pain? Y/N If yes, please describe: _______________________________________
____

Please indicate any treatment or concerns for the following medical problems:

___Head injury (concussion, loss of consciousness)
___Seizure
___Recurrent headaches
___Recurrent stomachaches or digestive problems
___Asthma
___Diabetes
___Syncopal Episodes (passing out)
___Palpitations (fast or irregular heart beat)
___Kidney disease
___Liver disease
___Heart disease
___Hearing impairment
___Glaucoma
___Thyroid disease
___Arrhythmias
___Anemia

Females:

First Menstrual Period: _________________

Last Menstrual Period: _________________

Are your cycles regular (if applicable)? Y/N Interval? _________

Have you ever missed school or other activities due to cramping or other issues related to your menstruation (if applicable)? Y/N

Please list any hospitalizations for medical illness (hospital, date, reason):
____
____

Please list any surgeries (hospital, date, reason):
____
____

Please list any drug, food or environmental allergies and describe the reaction (s):
____

Other medical problems/concerns:
____
____
____

Family History

Please list any family psychiatric history:

	Depression	Anxiety	Bipolar Disorder	OCD	Schizophrenia	Alcohol/Drug Problems	Learning problems	Hyperactivity	Attempts/Suici	Eating Disorders	Mental Retardation	Autism	Criminal Behavior	Psychiatric Hospitalization	Domestic
Father															
Father's Father															
Father's Mother															
Father's Siblings															
Mother															
Mother's Father															
Mother's Mother															
Mother's Siblings															
Siblings															

List any medications taken by relatives
(relationship/medication):____
____
____

Please indicate a family history of any of the following:

___ Syncopal Episodes (passing out)
___ Sudden death in children or young adults
___ Diabetes
___ Genetic Disorders
___ Cancer
___ High Blood Pressure
___ Cystic Fibrosis
___ Heart Disease
___ Death before age 50
___ High Cholesterol
___Blood clots
___Dementia/Alzheimer's
___ Stroke
___ Sickle Cell Anemia

Please list all medications current and previously taken. Include over-the-counter medications such as cold or allergy preparations, as well as any herbal or naturopathic medicines.

Name of Medication	First Use (mm/dd/yy)	Last Use (mm/dd/yy)	Maximum Dose	Period of use at highest dose	Helpful?	Side Effects?	Why did you stop?

Developmental History

Yes / No Was the patient conceived with the aid of medical intervention (i.e. donor egg, donor sperm, surrogate, IUI, IVF, etc.)?

Yes / No Was the patient adopted?

Yes / No Was the pregnancy planned?

Yes / No Did the patient's biological mother have any medical problems during the pregnancy?

Yes / No Did the patient's biological mother take any medications during the pregnancy?

Yes / No Did the patient's biological mother use alcohol, tobacco, or drugs during the pregnancy?

***If yes to any of the above, please describe:
____
____

At how many weeks gestation did the delivery occur? _____________________________

Birth weight: ______________ APGAR Scores (if known): ______________________

Yes / No Were there any medical complications associated with delivery (e g., premature delivery, caesarean section, forceps delivery, emergency delivery, meconium etc.)? If yes, please describe: ____

Yes / No Were there any medical problems as a newborn (e g , low birth weight, jaundice, breathing problems, neurological problems, admission to the NICU, etc.)? If yes, please describe: ____

Describe temperament as an infant:

Yes / No Were there delays in motor development (age at which you rolled over, sat up, stood, walked, ran, etc.)? If yes, please describe:

Yes / No Were there delays in speech and language development (age at which you babbled, spoke first word, used two word combinations, etc)? If yes, please describe:

Age at which the patient achieved toilet training: Bladder/Bowel:
____________/____________

Since being toilet trained, has the patient had any issues with:
Yes / No Wetting/soiling at night? If yes, until what age? ______

Yes / No Wetting/soiling the day? If yes, until what age? ______

As an infant, toddler, and preschooler, were there any issues with any of the following?
Yes / No Any problems with sleep?
If yes, please describe: ____
Yes / No Any problems with eating?
If yes, please describe: ____

Yes / No Any unusual or particularly severe fears?
If yes, please describe: ____

Yes / No Particular difficulty separating from caregivers?
If yes, please describe: ____

Yes / No More frequent or severe temper tantrums than other children?
If yes, please describe: ____

Yes / No More restless or hyperactive than other children?
If yes, please describe: ____

Issues with getting along with other children?

Favorite activities, hobbies, and pastimes?

Greatest strengths?

Academic History

Highest/recent level/grade: ____________________

Current School/University: ________________ Number of years in this school? _______

Yes / No Ever have an IEP/504/Accommodation plan?
If yes, please describe: ____

Yes / No Ever been left back in school?
If yes, please describe: ____

Yes / No Ever skipped a grade?
If yes, please describe: ____

Yes / No Ever been in special education classes?
If yes, please describe: ____
GPA: _____________
Yes / No Have teachers or others ever suggested there may be a learning disability? If yes, please describe:

Yes / No Ever received educational or cognitive testing? If yes, when and where did this testing occur? What were the results?

*** Please bring any testing reports to the first appointment.**

Yes / No Has a teacher ever commented about displays of emotional or behavioral difficulties in school? If yes, when and what were you told?

Please describe any other concerns you have about academic progress:

Employment:
Please list any concerns you have about your employment (past/present/future):

Legal History:
Are you currently involved in any legal problems? Y/N If yes, please describe.

Have you had any past convictions, charges, or suits against you? Y/N If yes, please describe.

Are you currently involved with child welfare, juvenile services, CPS, APS, family preservation, foster care, or adult services? Y/N If yes, please describe.

Home

Please describe the current living situation (i.e. who lives in the home, is there a split household, etc.):

Living in household with the patient:
Name: _______________________________ Age/Relationship: ___________________
Name: _______________________________ Age/Relationship: ___________________
Name: _______________________________ Age/Relationship: ___________________
Name: _______________________________ Age/Relationship: ___________________

Family members **not** living in the household:
Sibling Name: __________________________Age/Relationship: ___________________
Sibling Name: __________________________Age/Relationship: ___________________
Name: _______________________________ Age/Relationship: ___________________
Name: _______________________________ Age/Relationship: ___________________

Yes / No   Are there any pets in the household? If yes, please list:

Yes / No   Are there any firearms in the household? If yes, please describe the nature and number of the firearms, where/how they are stored, where/how they ammunition is stored:

Yes / No   Do any family or household members currently suffer from significant health problems? If yes, please describe:

Father's highest educational attainment/occupation: ____________________________

Mother's highest educational attainment/occupation: ___________________________

Yes / No   Are there currently or have there been any significant marital problems or family stressors? If yes, please describe:

Reviewed by: ____

Date: ___________

Comments: