



4350 EAST-WEST HIGHWAY
SUITE 200
BETHESDA, MD 20814

PH: 888.715.1120
FX: 888.715.1130
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 & EMERGENCIES

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: _____



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A Team Approach to Superior Care.

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Credit Card Authorization Form

****The card will be charged in accordance with our office and cancellation policies.****

Today's date _____/_____/_____ Patient Name: _____

Credit Card Information

Name as it appears on the Card:

Type of Card: VISA MASTERCARD DISCOVER AMERICAN EXPRESS

Credit Card Number _____ Expiration Date ____/____

Security Code BACK of Visa OR Master Card: (3 digits) _____

Security Code FRONT of Amex Card: (4 digits) _____

Credit Card Billing Address: Street: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____

****I hereby authorize this card to be used for payment of services rendered.**

Cardholder's Signature: _____ Date: ____/____/____

I hereby authorize this card to be used for payment of future services rendered (please sign again for future authorization):

Cardholder's Signature: _____ Date: ____/____/____

This Authorization can be faxed to 888-715-1130 or mailed to the address above

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 health/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)

Patient Name: _____

Patient Date of Birth: ____ / ____ / _____

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.):

Patient Name: _____

Patient Date of Birth: ____/____/____

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)

Kidney disease

Seizure

Liver disease

Recurrent headaches

Heart disease

Recurrent stomachaches or digestive problems

Hearing impairment

Asthma

Glaucoma

Diabetes

Thyroid disease

Syncopal Episodes (passing out)

Arrhythmias

Palpitations (fast or irregular heart beat)

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/Suicide	Disorders	Eating Disorders	Retardation	Mental	Autism	Criminal Behavior	Hospitalization	Psychiatric	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:

- | | |
|---|---|
| <input type="checkbox"/> Syncopal Episodes (passing out) | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Sudden death in children or young adults | <input type="checkbox"/> Death before age 50 |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Genetic Disorders | <input type="checkbox"/> Blood clots |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Dementia/Alzheimer's |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Sickle Cell Anemia |

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: