MetroNBI Personal History Questionnaire

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name:	☐ M ☐ F	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		
PCP or referring doctor:		**Date of last physical exam:**

PERSONAL HEALTH HISTORY

Reason for Visit: ☐ Depression ☐ Bipolar Disorder ☐ Anxiety ☐ ADHD/ADD ☐ PTSD ☐ Behavioral Issues ☐ Dementia ☐ Schizophrenia ☐OCD ☐ Poor Sleep ☐ Other: _____

Recent hospitalizations (psychiatric or otherwise):

Reason	Hospital

List all your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name & Dose	Frequency Taken	When was this medication started?

Allergic to medications? **Yes** ☐ **No** ☐ **If yes, Please list:**

List all previous tried **psychiatric medications,** when they were tried (approximately), and why they were discontinued:

Do you have a history of past psychiatric treatment? ☐ Yes ☐ No Is yes, who was your provider? _____			
Are you currently being treated for any of the following chronic disorders?	☐ HIV	☐ Sleep Apnea	☐ MultipleSclerosis
	☐ Lupus	☐ TBI/Head Injury	☐ Cancer
	☐ Arthritis	☐ CHF	☐ COPD ☐ Other:

If you checked any above, please comment here on length of diagnosis and current treatment:

_____

_____

OVERVIEW OF MEDICAL HISTORY

Check and describe briefly if you currently have, or have had, any symptoms or problem in any of following areas to a significant degree and briefly explain.

☐ Skin	☐ Reproductive Health	*Recent changes in:*
☐ Head/Brain injury/Neck	☐ Back	☐ Weight
☐ Ears/Nose/Throat	☐ Intestinal	☐ Energy level
☐ Lungs/Respiratory	☐ Bladder	☐ Ability to sleep
☐ Chest/Heart	☐ Bowel	☐ Other pain/discomfort:
☐ Kidneys	☐ Recent Surgeries	

Please describe briefly:

_____

_____

_____

HEALTH HABITS

Do you drink Alcohol? If yes, How much alcohol? _____/day /week/month	☐ Yes	☐ No
Do you smoke cigarettes? If yes, How much and how often? _____/day and how long have you smoked? _____years	☐ Yes	☐ No
Do you have a history of any substance abuse?	☐ Yes	☐ No
Are you addicted to or abuse legal or illegal drugs?	☐ Yes	☐ No
Do you drink coffee or caffeinated beverages? If yes, how much and how often? _____/day	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you exercise regularly?	☐ Yes	☐ No
Do you feel comfortable with your weight?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever had a sleep study? If yes, when? _____	☐ Yes	☐ No
Have you ever had a seizure? If so, when was your most recent seizure? _____	☐ Yes	☐ No
Do you have any history of head injuries or concussions? If yes, when? _____	☐ Yes	☐ No
Have you ever been to a counselor? If yes, who? _____	☐ Yes	☐ No

_____ _____

Patient/Guardian Signature

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Metropolitan Neuro Behavioral Institute

Date

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Metropolitan Neuro Behavioral Institute

CONSENT TO TREAT

I hereby voluntarily apply for treatment from Metro NBI Practitioners.

I hereby authorize the release of medical information necessary to process billing claims. I also authorize payment of medical benefits to Metropolitan Neuro Behavioral Institute for all services rendered.

I understand that I am financially responsible for all charges whether or not they are paid by my insurance company.

I also understand that appointments must be cancelled at least 24 hours in advance to avoid late cancellation or no-show fees.

Metropolitan Neuro Behavioral Institute and their affiliates participate in programs for training health care personnel. Students, interns, residents, and Licensed Associate Counselors (LAC) may participate in your treatment recommendations, conduct assessments, provide counseling, or be present at various times during your sessions. You can decline student services at any time.

☐ Patient is a minor whose parents are divorced with joint custody in matters of treatment. Both parents must sign this consent. It is the accompanying parent's responsibility to communicate treatment changes, decisions for care, and medication changes with non-attending parent. **Legal Custody/Divorce Decree papers must be provided at patient's first appointment with both parent's signatures before minor can see the provider without exception.**

☐ Patient is a minor whose parents are divorced and the non- accompanying parent has no legal authority in making decisions for the minor. **Legal Custody/Divorce Decree papers must be provided at first appointment before seeing the provider without exception.**

If you have any concerns or questions regarding medical students, medical interns, or medical residents you may contact Dr. Patino at (480) 464-4431.

_____	_____
Patient Name	Date
_____	_____
Patient/Guardian Signature	Date
_____	_____
Additional Guardian Signature (if required)	Date
_____	_____
Office Witness	Date

Lauro Amezcua-Patino, MD, FAPA
Lauren Kiraly, MMS, PA-C
Nicole Allsworth, MSPAS, PA-C
Karen Van Wie, PMHNP-BC
Chitra Mathew, DNP, PMHNP-BC
Brian Thomas, PMHNP-BC
Carolyn Boles, LPC

70 N. McClintock Dr. Suite #4
Chandler, AZ 85226
phone 480.464.4431
fax 480.464.2338
www.metronbi.com

PERMISSION TO COMMUNICATE WITH FAMILY & FRIENDS

☐ I choose to allow the people listed below to receive information regarding my appointment dates and times and billing issues. I understand this authorization may be revoked at any time. No aspects of care nor medical records will be released to them without a HIPAA compliant release of information being signed.

☐ I choose to **not allow** anyone participate in my care and am aware that only I will be able to receive information regarding my appointment dates and times, billing issues, or any aspects of my care unless it is a life-threatening emergency.

Parents: If your child is **over 18 years of age** and you are not their legal guardian, this form MUST include you for us to be able to discuss your child's appointment dates and times and billing issues.

NAME	PHONE NUMBER	RELATIONSHIP TO PATIENT
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

☐ I choose to allow the stepparent/s _____, _____ to bring minor to appointment, make appointments and receive information.

☐ I do not choose to allow the stepparent/s _____, _____ to bring minor to appointment, make appointments and receive information.

_____ _____
Patient Name Date

_____ _____
Patient Signature Date

_____ _____
Office Witness Date

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METROPOLITAN NEURO BEHAVIORAL INSTITUTE, PLLC
CLINICAL CONDITIONS OF EVALUATION AND TREATMEI

The undersigned _____ acknowledges having scheduled a voluntary Psychiatric evaluation for diagnostic and treatment purposes with Metropolitan Neuro Behavioral Institute (Metro NBI).

I acknowledge that I was provided with instructions about the evaluation process, and that the evaluation may include the completion of multiple forms for the collection of clinical information, as well as an interview with a Metro NBI provider.

After completion of the initial evaluation, I may be provided with the available diagnostic findings, and I am in agreement that at this point a decision can be made by either party to establish, or not, a provider-patient relationship. In the event of either myself refusing to continue with services or Metro NBI deciding to not be my provider, I will be given the name of at least 3 local psychiatric physicians capable of providing me with a second opinion and further care.

I acknowledge that Metro NBI practitioners will not provide me or my family with formal Psychotherapy Services beyond supportive therapy in the context of medication management and psychiatric assessment. If my Metro NBI provider recommends formal Psychotherapy Services it is my sole responsibility to procure and secure those services.

I acknowledge that the completion of disability, school, and other employment forms is beyond the scope of the provider's medication management practice and appointments, and not considered part of the evaluation or medication management reimbursement fee. I may be charged a fee based on the time and complexity of the form.

I understand that my medication management visits are scheduled for 15 minutes. If I arrive 8 minutes late to my appointment based on our clock, I will be considered as having missed my appointment, and will be rescheduled for next available appointment. A medication refill will be provided. I also recognize that if I don't cancel my appointment at least 24 hours in advance a fee of $50.00 will be charged to my account. I understand that occasionally, Metro NBI providers and staff will run late on their schedules due to unexpected patient situations.

Please initial:

I acknowledge that Metropolitan Neuro Behavioral Institute and its practitioners **DO NOT** provide Emergency Psychiatric or Continuous Crisis Management Services. I agree to call 911 or visit my closest Emergency Room or Psychiatric Urgent Care Center/Hospital in the event of a Psychiatric Emergency.

I understand that Metro NBI provider schedules are filled in advance and do not allow for patients to be seen on an urgent basis unless there is a cancellation. I understand it is my responsibility to ensure my follow-up appointments are maintained and scheduled as directed by my provider.

I acknowledge as part of my treatment, my provider will require me to obtain blood work and/or a urine drug screen. This may be new blood work and/or urine drug screen testing if the provider deems it a clinical necessity. If lab work was done recently through a coordinating physician, new lab work may not be necessary. Blood work and/or urine drug screens may be required on an ongoing basis throughout my treatment and my provider will discuss this with me.

I also acknowledge that Metro NBI providers do not provide Emergency Medication refills. It is my responsibility to assure that an adequate supply of medications **is always maintained.** Medication refills need to be requested at least 4-5 days before running out of the most recent medication supply. I understand that medication refills will be completed within 3 business day, and that medication prior authorizations will be completed within 7-10 business days from receipt of the request, depending on insurance company. Any questions regarding medications or treatment should be directed to your provider at 480-464-4431, option 3 or 5 or via email at nurse@metropsych.com.

I am aware and agree that Metro NBI will terminate my clinical services upon my verbal or written request.

I am aware and agree that Metro NBI may terminate my clinical services due to the following

- My failure to maintain compliance with at least 2 consecutive schedule appointments without prior notification

- Any abuse or misuse of prescribed medication
- Any dangerous behavior toward staff or providers
- My unwillingness to comply with recommended treatment recommendations, if in the opinion of the Metro NBI provider, my lack of compliance places me or other people in danger.
- The initiation of involuntary Commitment Proceedings.

AS A REMINDER:

-I understand that my medication management visits are scheduled for 15 minutes; if I arrive **8 minutes late** to my appointment based on our clock, I will be considered as having missed my appointment. I will be rescheduled for the next available appointment. A medication refill will be provided at no charge.

- I also recognize that if I do not cancel my appointments at least 24 hour notice a fee of $50.00 will be placed on my account. I understand that Metro NBI providers will run late on their schedules due to unexpected patient situations.

By initialing this box, you acknowledge that you have read and understand this reminder:

- Medication refills **must be requested at least 3-5 business days prior to running out of medication supply.** This can be done by contacting your local pharmacy directly prior to running out of medications. If authorization is needed our staff will address your requests in a timely manner. If you have a question about refills, please email or call the nurse/medical assistant directly: 480-464-4431 or nurse@metropsych.com.

-If you are in need of a refill, **please always contact your pharmacy first**, even if your medication bottle says no refills remaining. As long as you have a follow-up appointment scheduled with our office, refills can and will be authorized. Your pharmacy will fax us a request.

- I acknowledge as part of my treatment, my provider will require me to obtain blood work. This may be new blood work if the provider deems it necessary or from a coordinating physician if the lab works is recent. This will be necessary on an ongoing basis throughout my treatment and my provider will discuss this with me

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I understand that in the event of service being terminated (except in cases of involuntary commitment) I may be provided with a 30 day supply of medications (if applicable) and the name of 3 local Psychiatrists that may be available to provide me with Clinical Psychiatric Services. I also understand I may request a copy of this agreement at any time.

Patient Name:_____

Patient or Parent Signature_____

Today's Date:_____

Witness Name & Initials:_____

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Metropolitan Neuro Behavioral Institute

Lauro Amezcua-Patino, MD, FAPA
Lauren Kiraly, MMS, PA-C
Nicole Allsworth, MSPAS, PA-C
Karen Van Wie, PMHNP-BC
Chitra Mathew, DNP, PMHNP-BC
Brian Thomas, PMHNP-BC
Carolyn Boles, LPC

ACKNOWLEDGEMENT OF RECEIPT OF METROPOLITAN NEURO BEHAVIORAL INSTITUTE'S NOTICE OF PRIVACY PRACTICES

Patient Name_____ Date of Birth_____

I have been allowed to review and/or have received Metropolitan Neuro Behavioral Institute's Notice of Privacy Practices.

_____ Today's Date:_____

Patient's Signature or legally authorized individual

You May Refuse to Sign This Acknowledgement

****

For Office Use Only

Metropolitan Neuro Behavioral Institute could not obtain a written acknowledgement of receipt of our Notice of Privacy Practice due to the fact:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited it
- ☐ An emergency situation prevented us
- ☐ Other (please specify)

Employee Signature _____ Date _____

****

Metro NBI
Metropolitan Neuro Behavioral Institute

Terms of Agreement for Patients with AHCCCS Insurance as Secondary Insurance Seeking Treatment at Metropolitan Neuro Behavioral Institute

1. I understand that Metropolitan Neuro Behavioral Institute (Metro NBI) does not hold a contract with swith Arizona Health Care Cost Containment System (AHCCCS) insurance as primary insurance and hereby confirm that I do not have AHCCCS insurance as a primary policy.

   _____
   (initial)

2. I confirm that I have private insurance as my primary policy and AHCCCS insurance as a secondary policy.

   _____
   (initial)

3. I understand and agree to the following terms as a patient receiving treatment at Metro NBI:

   - If my primary (private) insurance does not cover a service provided at Metro NBI and/or a medication prescribed to me by my provider, I am solely responsible for the out-of-pocket cost of the service and/or medication.

     _____
     (initial)

   - Metro NBI <u>cannot</u> and <u>will not</u> submit claims to AHCCCS.

     _____
     (initial)

   - Metro NBI will not be responsible for prior authorizations for medication coverage through AHCCCS or MMIC.

     _____
     (initial)

_____ _____
Patient signature date

If you are unable to agree to the terms provided in this agreement and need help obtaining a provider who can treat you, you can call the AHCCCS toll-free number at 1-800-654-8713 or visit the AHCCCS website at http://www.azahcccs.gov.

_____ _____
Employee witness date

☐ Not applicable (Check here if you do not have AHCCCS as a primary or secondary insurance policy.)

_____ _____
Patient signature date