SHIFA HEALTH

NEW PATIENT INFORMATION

Date: _____

Patient name: _____ DOB: _____ Age: _____

Address: _____ City/State/Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Sex: ____ Male ____ Female Marital Status: _____ SS#: _____

Emergency Contact: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

Pharmacy Name: _____ Phone #: _____

Referred by: _____ Reason for Referral: _____

PRIMARY INSURANCE INFORMATION (Please complete information for policy holder)

Primary Card Holder Name: _____ DOB: _____

Relationship: _____ Insurance Company: _____

Insured ID#: _____ Group #: _____ Phone #: _____

Attorney (if L&I): _____

Employer name: _____ Phone #: _____

SECONDARY INSURANCE INFORMATION (Please complete information for policy holder)

Secondary Card Holder Name: _____ DOB: _____

Relationship: _____ Insurance Company: _____

Insured ID#: _____ Group #: _____ Phone #: _____

Employer name: _____ Phone #: _____

COORDINATION OF CARE

It is important for your health care providers to speak to each other so we may work together to help you. Please complete the Information below and indicate your approval for us to coordinate care.

Primary Care Physician: _____ Phone #: _____

Address: _____ City/State/Zip: _____

May we contact your physician: _____ YES ____ NO _____ I do not have a physician

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

____ No _____ Yes, previous therapist/ Practitioner: _____

CURRENT INFORMATION

Reason for appointment: _____

Appetite issues or changes: _____

Concentration issues or changes: _____

Sleep issues or changes: _____

Losses in the past few years: (Deaths, relationships, jobs, etc.) _____

_____

MEDICAL HISTORY

Allergies: ____ none ____ Allergic to: _____Date of last Physical exam: _____

Surgeries: _____

Medical Conditions: _____

CURRENT MEDICATIONS (Dosage, frequency-including supplements and over-the counter medications)

_____

_____

How would you rate your current physical health? (Please circle)

Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific health problem you are currently experiencing:

_____

Are you currently experiencing anxiety, panic attacks, or have any phobias?

_____ No _____ Yes

Are you currently experiencing any chronic pain?

_____ No _____ Yes If yes, please describe: _____

How often do you engage recreational drug use?

Daily Weekly Monthly Infrequently Never

What significant life changes or stressful events have you experienced recently?

_____

_____

_____

Family Medical Health History:

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.)

	Please circle	**List Family Member**
Alcohol/ Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Behavior	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	
Obsessive Compulsive	yes/no	

Additional Information:

1) Are you currently employed? _____ No _____ Yes

If yes, what is your employment situation? _____

Do you enjoy your work? Is there anything stressful about your work?

_____

What would you like to accomplish out of your time in therapy/ treatment?

_____

PSYCHIARTIC HISTORY (include treatment dates, name of provider[s])

Psychiatric admissions: ___ No ___ Yes- Where & dates _____

_____

Chemical dependency admissions: ___ No ___ Yes- Where & dates _____

Outpatient treatment: ___ No ___ Yes- Where & dates, previous Psychiatrists name _____

_____

Suicide attempts: ___ No ___ Yes-How and when _____

Past psychiatric medications: ___ No ___ Yes- What meds & response? _____

ADDITIONAL INFORMATION

Have you felt down, depressed or hopeless in the past two weeks? ___ No ___ Yes

Have you felt little interest or pleasure in things you used to enjoy in the past two weeks? ___ No ___ Yes

Patient signature: _____

Are you allergic to any medication? ___ No ___ Yes if yes, please list _____

PAST MEDICAL HISTORY

Please circle Yes or No

Diabetes	Yes	No	Cancer	Yes	No	Arthritis	Yes	No
Chest Pain/Angina	Yes	No	Osteoporosis	Yes	No	Heart Surgery	Yes	No
High Blood Pressure	Yes	No	Asthma/COPD	Yes	No	Blood Clots	Yes	No
Heart Disease	Yes	No	Stroke/CVA/TIA	Yes	No	Peripheral Vascular Disease	Yes	No
Heart Attack	Yes	No	Seizures	Yes	No	Tuberculosis	Yes	No
High Cholesterol	Yes	No	HIV/AIDS	Yes	No	Depression	Yes	No
Pacemaker	Yes	No	Hepatitis	Yes	No	Congestive Heart Failure	Yes	No
Headaches	Yes	No	Stomach Ulcer	Yes	No	Thyroid Disease	Yes	No
Kidney Stones	Yes	No	Liver Disease	Yes	No		Yes	No
Kidney Disease	Yes	No	Heart Palpitations	Yes	No		Yes	No

Other: (please list) _____

ROS	Please circle all CURRENT positive findings
Constitutional	Weight loss Fevers Chills Poor Appetite Fatigue Weight Gain Insomnia Night Sweats
Eyes	Blurry Vision Eye Pain Eye Discharge Eye Redness Decrease in Vision Dry Eyes Double Vision
ENT	Sore Throat Hoarseness Ear Pain Hearing Loss Ear Discharge Nose Bleeds Tinnitus Sinus Problems
Cardiovascular	Chest Pain Palpitations Rapid Heart Rate Heart Murmur Poor Circulation Swelling in Legs or Feet
Respiratory	Shortness of Breath Chronic Cough Coughing up Blood History of Tuberculosis Excess Sputum Production
Gastrointestinal	Nausea Vomiting Diarrhea Constipation Blood in the Stool Frequent Heartburn Trouble Swallowing
Genitourinary	Increase Urinary Frequency Blood in Urine Incontinence Painful Urination Urinary Retention Frequent UTIs
Skin	Rash Hives Hair Loss Skin Sores or Ulcers Itching Skin Thickening Nail Changes Mole Changes
Musculoskeletal	Joint Pain Muscle Aches Frequent Leg Cramps Muscle Weakness Bone Pain Joint Swelling Back Pain
Psychiatric	Anxiety Depression Alcohol or Drug Dependence Suicidal Thoughts Panic Attacks Use of Anti-Depressants
Endocrine	Goiter Heat Intolerance Cold Intolerance Increased Thirst Change in Skin Pigment Excess Sweating
Neurological	Seizures Tremors Migraines Numbness Dizziness/Vertigo Loss of Balance Slurred Speech Stroke
Hem/Lymphatic	Low Blood Count Easy Bruising Swollen Lymph Nodes Transfusions Prolonged Bleeding Blood Clots
Allergic/Immune	Allergic Reactions Hay Fever Frequent Infections Hepatitis HIV Positive Positive Tuberculosis Skin Test (PPD)

Social History: Marital Status _____ Occupation (or most recent job held) _____

____ Non-Smoker (never Smoked) ___ Ex-Smoker ___ Current Smoker How many packs per Day? ____

Alcohol Consumption: ___ Never ____ Occasional ___ Frequent

Family History: (Please list any known medical problems)

Father: _____ Mother: _____

Siblings:_____ Your Children: _____

Additional information: Use this space to provide any additional information that may be important to your health care.

_____ _____

Signature of Reviewing Physician Date Signature of Patient Date

PATIENT NAME: _____ DATE: _____

PHQ-9

	Over the <u>last 2 weeks,</u> 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 your 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 notice? Or the opposite-being so fidgety or restless that your 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
	PHQ-9 TOTAL SCORE:				

Q6 CORE 10	I made plans to end my life in the last 2 weeks	NO	YES

GAD-7

	Over the <u>last 2 weeks,</u> 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	Feeling nervous, anxious or on edge	0	1	2	3
2	Not being able to stop or control worrying	0	1	2	3
3	Worrying too much about different things	0	1	2	3
4	Trouble relaxing	0	1	2	3
5	Being so restless that it is hard to sit still	0	1	2	3
6	Becoming easily annoyed or irritable	0	1	2	3
7	Feeling afraid as if something awful might happen	0	1	2	3
	GAD-7 TOTAL SCORE:				

SHIFA HEALTH, PLLC
FINANCIAL POLICY

Thank you for choosing Shifa Health, PLLC as your healthcare provider. We are committed to your treatment being successful. We feel that it is very important that our patients have a clear understanding of our expectations regarding your billing and payment. Please read and sign the following Financial Policy prior to your treatment. By signing this agreement, you are agreeing to pay for all services that are received. Should you have any questions, feel free to ask.

Our office may assist you with your insurance billing. To do this we need all your insurance information. It is your responsibility to keep our office informed of all changes in your address, telephone number and insurance carrier detail.
If we do not have the correct insurance information at the time of the visit, you will be responsible for all charges for that day.

FULL PAYMENT FOR PRIVATE PAY APPOINTMENTS AND CO-PAYS ARE DUE AT THE TIME OF SERVICEE. WE ACCEPT CASH, CHECK, VISA, MASTERCARD AND HSA.

Initial: ____ Co-pays: Co-pays are due at the time of service. **If a co-pay is not paid at the time of service an additional** $**10.00 fee will be added to the billing statement.**

Initial: ____ No show appointments and late cancellations: If you are unable to make your scheduled appointment, please let us know 24 hours in advance so that we may give another patient that time. **There is $75.00 charge for all No Shows or Late Cancellations.** These charges are your responsibility as insurance companies do not pay for no show appointments or late cancellations. If you are late for your scheduled appointment and you are still seen for the remaining scheduled time, you will still be charged for the full appointment time.

Initial: ____ Labor and Industries Patients: Labor and Industries requires an authorization by your claim manager to be seen by a provider.
If there is no Labor and Industries authorization and you continue to be seen by the provider, you will be responsible for the provider charge for that date of service.

Initial: _____Provider Cancellations: Please give the best contact number so we can inform in case cancel and reschedule with you.

Initial: _____If you are having financial difficulty, contact our Billing Specialist, who will be able to assist you. You may want to establish a payment plan. **The monthly payment amount must be approved by the billing specialist.** If so, we ask that these payments be made as scheduled, each month and on time. If payments are not received on a regular monthly basis, we have the right to turn the account over to collections. We do monitor these accounts and non-payment may jeopardize your ability to be seen by our providers.

- We reserve the right to change billing fees.
- We reserve the right to opt in or out of any insurance plan at any time.
- We reserve the right to terminate care in case of non-payment on account balance, no shows or non-compliance with the treatment plan.
- We reserve the right to change or modify this financial policy at any time without further notification.

Name (printed) _____ Date: _____

Signature: _____

AUTHORIZATIONS AND AGREEMENTS

Please read carefully and sign below

Medical Insurance: I authorize my medical insurance company to pay directly to Shifa Health, PLLC for any services. However, I understand that I am responsible for all my fees, including any fees not paid by the insurance company. I have been notified that sometimes health plans deny payment for service for reasons like:

- The physician is not a participating provider
- The requested procedure is not covered by the health plan
- Incomplete or invalid insurance information provided
- Lapse of coverage at time of service
- Expired authorization and/or referral
- Service not considered necessary and reasonable or any other reason
- Waiting period for pre-existing condition

Release of Information: I authorize Shifa Health, PLLC to release information about me **to my medical insurance company and my referring physician.**

By signing below:

1. I state my desire to receive the service(s)
2. I recognize my financial responsibility for the service(s)
3. Unless other arrangements are made, I agree to pay all bills to the clinic at the time of service
4. Acknowledge receipt of the Financial Policy Agreement

Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may get more information about your records by contacting the receptionist.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed and how you can access your information.

Print Patient name: _____ Date: _____

Signature: _____

Relationship if other than patient: _____