Release of Patient Information Form

Please complete this form if you would like our office to inform your Primary Care Provider that you are being treated by American Trinity Psychiatry, PLLC:

Today's Date: _____

Client Name:_____DOB:_____

Primary Care Office: _____

Phone number:_____Fax: _____

This letter is to inform my primary care doctor that I am receiving services at American Trinity Psychiatry, PLLC for the following Symptoms or Diagnosis:

_____

I plan to receive the following treatments while in the care of American Trinity Psychiatry, PLLC for:

____ Therapy

____ Medication to reduce mental health symptoms

____ Both

I give American Trinity Psychiatry, PLLC and my PCP office, listed above, permission to share my private health information with each other. This consent does not expire until I submit written request to terminate communication.

_____

Client Signature Date

_____

Provider or Administrative Staff Signature Date

Consent to Release Information

I consent for American Trinity Psychiatry, PLLC and those representing this group to share my private healthcare information with the following individuals and/or entities.
American Trinity Psychiatry, PLLC is permitted to send and receive information to and from the entities below if needed:

1. Representatives of Child's School (School Name)-_____

2. Primary Care Physician Name-_____

3. Emergency Contact Name-_____

4. Other/ Self-_____

I understand that I have the right to revoke this authorization, in writing, at any time by sending notice to for American Trinity Psychiatry, PLLC. I understand that a revocation is not valid to the extent that for American Trinity Psychiatry, PLLC has acted in reliance on such authorization. This authorization does not expire until I submit a written request. A copy of this release shall have the same force and effect as the original.

NOTICE TO RECEIVING PROVIDER OR ORGANIZATION: You may not re-disclose any of this information unless the person who consented to this disclosure specifically consents to such re-disclosure.

I understand that there is a potential for disclosure of this information by the recipient and, if that occurs, federal law may not protect the information.

_____

Client Name

_____ _____

Client/Guardian Signature Date

Please contact American Trinity Psychiatry, PLLC if you have questions regarding your medications or are in crisis. The receptionist will take detailed information to communicate to the clinician. If the crisis is outside the scope of service that can be safely addressed or after business hours you may be directed to go to the emergency department. It may be necessary for you to see the clinician, as not all issues can be addressed in a telephone format. All phone calls will be returned as quickly as possible, if you are in a crisis and your phone call has not been returned within 15 minutes call 911 or go to the nearest emergency room.

_____

Client Name

_____ _____

Client or Guardian Signature Date

American Trinity Psychiatry, PLLC.

MEDICATION REFILLS AND NEW PRESCIPTION

Medications will be refilled as medically indicated. If you find that your symptoms are not controlled on your medications, contact our office before making changes on your own. Early refills can't be provided without seeing the clinician. The clinician usually provides enough refills on your NON-CONTROLLED prescriptions to last until the next scheduled follow-up. It is likely that you need to be seen if you have no remaining refills on your prescription. Please call our office for an appointment.

Certain medications can't be refilled and will require a new prescription each month. This does not mean we need to see you each month, but you will need to call our office to request a refill prescription and a new prescription will be sent to your pharmacy, if medically appropriate, by the end of the next business day. Please request all non-controlled prescription refills through your pharmacy at least 3 days before you need the medication.

Be aware that if you have not been seen in our office within the last 90 days a controlled substance can't be prescribed. DUE TO INCREASED REGULATIONS ON CONTROLLED SUBSTANCES THEY WILL NOT BE REPLACED EVEN IF LOST OR STOLEN.

PRIOR AUTHORIZATION

Certain medications require prior authorization from the insurance carrier before they will pay for your medication. Your pharmacy will receive notice of the prior authorization requirement when they contact your insurance carrier for payment. At that time the pharmacy will send us notification of the requirement. Each insurance plan has its own requirements, so it is not possible to anticipate when a prior authorization will be required. We will process those requests as quickly as possible, usually within 48 hrs. A prior authorization can take up to a week for the carrier to process.

URINE DRUG SCREENS

New patients are asked to provide a urine drug screen at the initial visit. The initial screen is completed in our office. The clinician will let you know your results. This test will provide information for the clinician to determine what other medications you may be taking prior to prescribing additional medications. On occasion, it is necessary to send your urine drug screen to an outside lab for confirmation. If that is required, the clinician will inform you. There is an additional charge from the drug screening lab that will be billed to your insurance carrier or to you if you are uninsured. If the clinician prescribes certain controlled substances, you can anticipate random urine drug screens. (This is another regulatory requirement.)

PREGNANCY TESTS

Each female between 10-55 years of age will have a urine pregnancy test at the first office visit. Notify American Trinity Psychiatry, PLLC immediately if you become pregnant after being prescribed medication from American Trinity Psychiatry, PLLC. The clinician may need to modify your medication.

QUESTIONS

Have you ever had any legal issues? □ No □ Yes, If yes what type?_____

_____

Do you consider yourself to be spiritual or religious? □ No □ Yes If yes, describe your faith or belief:

_____

_____

What do you consider to be some of your strengths?

_____

_____

What do you consider to be some of your weaknesses?

_____

_____

What brought you into seek therapy?

_____

_____

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

_____

_____

_____

Client/Guardian Printed Name

_____ _____

Client/Guardian Signature Date

Birth control method _____

How many times have you been pregnant? _____ How many live births? _____

General and Mental Health Information

Current Symptoms (circle all that apply):

Fatigue or Lack of Energy	Decreased Interest in Activities
Excessive Guilt	Depressed or Sad
Mood Swings	Weight Changes
Appetite Change	Poor Concentration
Worthlessness	Decreased Libido
Hopelessness	Hallucinations/Hearing or Seeing Thing Not There
Panic Attacks	Decrease or Increased Sleep Pattern
Low self-esteem	Suspiciousness
Low Motivation	Excessive Energy
Excessive Worry	Irritability
Tearful/Crying	Anger
Suicidal/Homicidal Thoughts	Increased Energy/ Not needing Sleep

Other: _____

Please describe any past or current suicidal or homicidal thoughts, plans, or actions/attempts (If not applicable to you, please write N/A):_____

_____

Have you ever been the victim of or witness to trauma or abuse? □ No □ Yes If yes, please describe below. (ex: instances of sexual, emotional, physical abuse or neglect and/or being a victim of an accident, violent crime, or a natural disaster.)_____

_____

_____

How would you rate your current physical health? (Please circle one): Poor, Good, Very Good

Please list any specific physical health problems you are currently experiencing:

_____

_____

Are you currently experiencing any chronic pain? □ No □ Yes If yes, please describe:

_____

Tobacco History:

How you ever smoked cigarettes? □ No □ Yes

Currently Smoke? □ No □ Yes, If yes, how many packs per day on average? _____How many years? _____

In the past, how many years did you smoke? _____ When did you quit? _____

Pipe, cigars, vapor, e-cigarettes, chew tobacco, snuff/dip: Current use? □ No □ Yes; Used in the past? □ No □ Yes

What kind? _____ How often per day on average? _____ How many years? _____

Do you drink alcohol more than once a week? □ No □ Yes If yes, please list type of alcohol, how many days per week you drink and how many drinks you have per day:

_____

How often do you engage in recreational drug use? □ Daily□ Weekly □ Monthly □ Infrequently □ Never; If you do what type of drug (circle all that apply)? Marijuana, Cocaine, Heroin, Meth, Other:_____

_____

How would you rate your current sleeping habits? (Please circle one) Poor, Good, Very good; How many hours do you sleep at night?_____

Please list any specific sleep problems you are currently experiencing:

_____

Please list any difficulties you experience with your appetite or eating problems (put N/A if none):

_____

Are you currently experiencing overwhelming sadness, grief or depression? □ No □ Yes

If yes, for approximately how long?_____

Are you currently experiencing anxiety, panic attacks or have any phobias? □ No □ Yes

If yes, when did you begin experiencing this and what symptoms are you having?

_____

_____

Family History

Please Circle Yes or No	**Family Member's Relation to You**
Alcohol/Substance Abuse yes / no	_____
Anxiety yes / no	_____
Depression yes / no	_____
Domestic Violence yes / no	_____
Eating Disorders yes / no	_____
Obesity yes / no	_____
Obsessive Compulsive Behavior yes / no	_____
Bipolar Disorder yes/no	_____
Schizophrenia yes / no	_____
Suicide Attempts yes / no	_____
Completed Suicide yes/no	_____

Are you currently in school? □ Yes □ No If yes, name of school and grade or degree program:_____

_____

Highest grade completed or degree received:_____

Primary Care Provider:_____Phone: _____Fax:_____

History

Have you ever received any type of mental health services (psychotherapy, psychiatric services, etc.)? □ No □ Yes

Have you ever been diagnosed with any psychiatric issues? □ Yes□ No, If yes, please list diagnoses and when (age/year) you were diagnosed:_____

_____

_____

Are you currently taking, or have you ever been prescribed psychiatric medication? □ Yes□ No, If yes, please list medication, dosage and how long you have been taking medication.

_____ _____

_____ _____

_____ _____

Are you currently seeing a therapist, or have you seen one before? □ Yes□ No, If yes, please list therapist name and last time you were seen:_____

Current Therapist Phone:_____Fax:_____

Do you have any medical issue (ex: high blood pressure, diabetes, etc.)? □ Yes□ No, If yes please list:_____

_____

_____

Are you currently taking any prescription or over the counter medications? □ Yes□ No, If yes, please list.

_____ _____

_____ _____

_____ _____

Surgical History:

_____ _____

_____ _____

_____ _____

Allergies:

_____ _____

_____ _____

For women only:

Date of last menstrual period _____ Are you currently pregnant or think you might be pregnant? □ No □ Yes
Are you planning to get pregnant in the near future? □ No □ Yes

American Trinity Psychiatry, PLLC.

New Patient Intake Form

Please complete all information on this form and bring to your first visit, along with any recent lab results and the bottle or a detailed list of all prescribed and over the counter medication you are taking. If you are unable to complete it at home, please come 30-minutes prior to your scheduled appointment time to fill out in the office. You may need to ask family members about the family history. Thank you!

Personal Information

Name:_____Today's Date:_____

Parent/Legal Guardian (if under 18):_____

Address:_____City:_____State_____Zip Code_____

Phone:_____May we leave a message? □ Yes □ No

Email: _____ May we leave a message? □ Yes □ No

*Please note: Email correspondence is not considered to be a confidential medium of communication.

Date of Birth:_____Age:_____Gender at Birth:_____

Gender Identified as (circle one): Male, Female, Trans Male/Trans Man, Trans Female/Trans Woman, Genderqueer/Gender Non-Conforming, Different Identity:_____

Sexual Orientation (circle more): Heterosexual or Straight, Gay, Lesbian, Bisexual

Not listed above (please specify)_____

Marital Status:

□ Never Married □ Domestic Partnership □ Married

□ Separated □ Divorced □ Widowed

Number of children _____Children's Names & Ages:_____

_____

Are you currently employed? _____If yes, please indicate your job title/description:_____

_____

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

_____

NOTICE OF PAYMENTS

To all insurance companies and claims representatives:

Payments for billings for patients are to be made out, addressed and sent to **AMERICAN TRINITY PSYCHIATRY, P.L.L.C.** 22200 West Eleven Mile Road, Suite 224, Southfield, MI 48037 (248-251-0354) for all services rendered and billed. Payments are NOT to be sent to any other party including the patient, another provider, patient's attorney, caretaker, and/or any other representative of the patient.

*See attached signed "Payment Agreement." Also attached is an "Assignment of Benefits" signed by the patient and notarized.

_____ Date:_____

Signature of Patient and/or guardian

Printed Name:_____

_____ Date:_____

American Trinity Psychiatry, P.L.L.C.
22200 West Eleven Mile Road, Suite 224
Southfield, Michigan 48037
P: 248-251-0354
F: 248-218-0662

AMERICAN TRINITY PSYCHIATRY, P.L.L.C.

1655 Big Beaver
Troy, MI 48084
Phone (248) 251-0354
Fax (248) 218-0662

New Patient Information

Name_____

Address_____

City_____ State_____ Zip_____

Home Phone _____ SS#_____

Work Phone_____

Date of Birth_____

Payment Agreement

I understand that payment is due for services rendered at the time services are provided, and that I am responsible for payment.
I agree that I am responsible for submitting proof of payment made to American Trinity Psychiatry, P.L.L.C. and to my insurance company for reimbursement.
I agree that it is my obligation to provide my insurance company with any documents required to obtain payment for and on the behalf of American Trinity Psychiatry, P.L.L.C. for services provided.
I understand and agree that in the event payment for services rendered are not made and/or liens and/or satisfactory guarantees therefore are not signed by you and your attorney and provided to my office within 60 days of my first billing of your insurance company for services rendered, that no further services will be provided and my billings may be turned over to collection services to assure payment of such services.

Signature_____ Date_____