Pottsville Peace of Mind, LLC

21 S Centre Street

Pottsville, PA 17901

Phone: (272)-224-1604

Fax: (570)-628-5298

PATIENT INFORMATION

Full Name: _____ **Date of Birth:** _____

Address:_____**City:**_____**State:**_____**Zip Code:** _____

Home Phone: _____ **Cell Phone:** _____ **Social Security#:** _____

Email Address: _____**Sex:** ☐**Male** ☐**Female**

**Please note that email is not considered to be a confidential medium of communication, but is privately managed and seen by only the provider and her assistant.

Race: _____

Marital Status: ☐**Never Married** ☐**Married** ☐**Domestic Partnership** ☐**Separated** ☐**Divorced** ☐ **Widowed**

Occupation: _____ **Employer:** _____

EMERGENCY CONTACT INFORMATION

Full Name: _____ **Relationship:** _____

Address: _____ **City:** _____**State:** _____**Zip Code:** _____

Phone Number: _____

PHARMACY INFORMATION

Name: _____ **Phone Number:** _____**Town/Zip Code:** _____ **Allergies (include medications):** _____

WHO MAY WE THANK FOR YOUR REFERRAL?

Name: _____ Phone Number: _____

Address: _____

☐Google Search ☐Psychology Today ☐Don't Recall ☐Other _____

INSURANCE INFORMATION PRIMARY/SECONDARY	
Insurance Company	Insurance Company
Insurance ID#	Insurance ID#
Group#	Group#
Copay:	Copay:
** Name of Insured:	** Name of Insured:
** Date of Birth:	** Date of Birth:
** Insured's Phone Number:	** Insured's Phone Number:
Insured's Employer:	Insured' Employer:

Worker's Comp: ☐ Yes ☐ No Auto Accident: ☐ Yes ☐ No Date of Accident/Injury: _____

WCB/NF. Insurance Company: _____ Agent Name: _____

Address: _____ Phone Number:_____

Claim Number: _____ Case/Policy Number: _____

Please provide your Insurance Card and Picture ID to Teresa Blatt, PMHNP-BC to make a copy.

I hereby authorize my insurance benefits (e.g. Medicare) to be paid directly to Pottsville Peace of Mind, LLC. I will accept financial responsibility for non-covered services. If my account is sent to a collection agency, I agree that I will be responsible for all collection costs. I also authorize the office to release information about services rendered by my provider(s) to my insurance carrier(s) and allow a photocopy of my signature to be used to file insurance claims.

SIGNATURE: _____ DATE: _____

OFFICE PROCEDURES AND INSTRUCTIONS

Please call the office phone number at 272-224-1604. If it is a serious emergency situation, do not leave a message in the voice messaging system. Please note, we do not always check our voicemail or messages when the office is closed or over the weekend and holidays.

If there is a delay in the call back and you are in a serious life-threatening emergency, immediately proceed to the following steps:

- Call 911. In some cases, and depending on the situation, you may call the police or try to reach your PCP, a friend, relative, or neighbor.
- Go to the nearest emergency room for immediate help.
- You may also call the PA Crisis Hotline at 1-800-292-3866.

On your regular visits, please inform us of any changes in your health, abnormal lab work, pregnancy or new medications prescribed by other doctors.

On each office visit, please make sure you have enough medication to cover you until your next visit and also over weekends and holidays.

Our office is no longer able to call/fax routine prescriptions to the pharmacy for renewals.

Please note that we are unable to send any prescriptions over weekends, holidays, or after our normal business hours.

We do not authorize renewal of narcotics or controlled medications over the phone/fax at any time unless the appointment is covered by Telehealth (via Zoom)!

If you need to cancel/reschedule an appointment, we request a 24-48-hour notice. Our office will no longer be able to send partial prescriptions for missed appointments. For every No Show or Late Cancellation under 24 hours, our office has the right to charge a $100.00 fee that will fall under patient responsibility. After 3 No Shows or exceeding 15 minutes late to your appointment, the provider's services will discontinue due to a waiting list.

To prevent being billed for unauthorized visits, please provide us with appropriate referrals, authorizations, and changes in your insurance information. My assistant will gladly help you and provide information. If the office does not have your most current insurance information, you will be responsible for the services provided by the provider.
For billing questions/problems, please contact 272-224-1604.

** If patient is under 18, parent/guardian is responsible for payment of the minor's account balance. If so, parent/ guardian's Social Security Number is required to be in their chart and needs to be added below with their signature!

I, _____, have read and understood all the above procedures and instructions at Pottsville Peace of Mind, LLC
(Print Name.)

_____ _____ Patient Signature (If under 18, Patient's Parent/guardian and SSN) / Date

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LIMITS OF CONFIDENTIAL

Content of all appointment (Med Managing and Therapy) sessions are considered Confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

Duty to Warn and Protect: When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the healthcare professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults: If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances: Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Insurance Providers (when applicable): Insurance companies and other thirty-party payers are given information that they request regarding services to clients. Information that may be requested includes, but is not limited to types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I, _____, authorize this office and its staff to release protected health information

Patient's Name [Please Print]

related to my evaluation and treatment to the following:

PCP NAME: _____ PCP PHONE NUMBER: _____

THERAPIST NAME: _____ THERAPIST PHONE NUMBER: _____

FAMILY MEMBER NAME: _____ RELATIONSHIP:_____

FAMILY MEMBER PHONE NUMBER: _____

_____ _____

Patient Signature Date (If under 18, patient's parent/guardian) Today's Date

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MEDICAL HISTORY

1. Do you currently have a primary care physician? □Yes □No When was your last physical? _____
If yes, Dr's Name: _____
Phone Number:_____
Address:_____
2. Are you currently seeing more than one Medical Health Specialist? □Yes □No If yes, why?
_____

3. Please list any persistent physical symptoms or health concerns (e.g. strokes, headaches, epilepsy, glaucoma, asthma, heart, liver, and lung problems, hypertension, diabetes, recent surgeries ... etc.)
_____
_____

4. Are you currently on medication to manage a physical health concern? □Yes □No
If yes, please list:
_____
_____

FAMILY MENTAL HEALTH HISTORY

Are you adopted? □Yes □No
Has anyone in your family (immediate and/or extended relatives) experienced difficulties with the following:

Difficulty	Yes	No	Family Member
Depression	☐ Yes	☐ No	
Bipolar disorder	☐ Yes	☐ No	
Anxiety disorder	☐ Yes	☐ No	
Panic attacks	☐ Yes	☐ No	
Schizophrenia	☐ Yes	☐ No	
Alcohol/Substance Abuse	☐ Yes	☐ No	
Eating Disorder	☐ Yes	☐ No	
Learning disabilities	☐ Yes	☐ No	
Trauma history	☐ Yes	☐ No	
Suicide attempts	☐ Yes	☐ No	
Chronic illness	☐ Yes	☐ No	
ADHD/ADD	☐ Yes	☐ No	
Anger Management	☐ Yes	☐ No	

HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING?

Extreme depressed mood	☐ Yes	☐ No	If yes, since when?
Dramatic mood swings associated with rapid speech, high energy, and decreased sleep	☐ Yes	☐ No	If yes, since when?
Extreme anxiety	☐ Yes	☐ No	If yes, since when?
Panic attacks	☐ Yes	☐ No	If yes, since when?
Hallucinations	☐ Yes	☐ No	If yes, since when?
Sleep disturbances	☐ Yes	☐ No	If yes, since when?
Repetitive thoughts (e.g. obsessions)	☐ Yes	☐ No	If yes, since when?
Repetitive behaviors (e.g. frequent checking, hand washing ...)	☐ Yes	☐ No	If yes, since when?
Phobias	☐ Yes	☐ No	If yes, since when?
Unexplained losses of time	☐ Yes	☐ No	If yes, since when?
Unexplained memory lapses	☐ Yes	☐ No	If yes, since when?
Eating disorder	☐ Yes	☐ No	If yes, since when?
Body image problems	☐ Yes	☐ No	If yes, since when?

PAST PSYCHIATRIC HISTORY

1. Are you currently receiving psychiatric services, counseling, or psychotherapy? ☐ Yes, currently with (therapist/psychiatrists' name): _____ ☐ No, but in the past with (therapist/practitioner's name): _____

2. Have you ever been admitted to a facility for mental health treatment?
   ☐ Yes ☐ No If yes, where: _____

3. In the last year, have you experienced any significant life changes or stressors? □Yes □No If yes, please explain: _____

5. **Do you self-harm?** ☐ Frequently ☐ Sometimes ☐ Rarely ☐ Never

6. **Have you had suicidal thoughts recently?** ☐ Frequently ☐ Sometimes ☐ Rarely ☐ Never

7. **Have you ever attempted suicide or tried harming yourself?** ☐ Yes ☐ No If yes, when?
   _____

8. Which medications have you **taken in the past**?
   _____
   _____

9. Which medications are your **currently taking**? _____
   _____

10.Why are you here today? _____

ALCOHOL & DRUG HISTORY

1. Do you drink alcohol? ☐ Yes ☐ No If yes, how much do you drink a day? _____ A week? _____

2. Do you engage in recreational drug use? ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never If yes, please list . 1._____ 2. _____ 3. _____
   Since when? _____

3. Have you been in detox or rehab? ☐ Yes ☐ No If yes, when? _____

4. Do you smoke cigarettes or use other tobacco products? ☐ Yes ☐ No If yes, which ones? _____

PSYCHOTROPIC MEDICATION INFORMED CONSENT AND CONSENT FOR TREATMENT

NAME_____ DOB _____ I have reviewed the following medications and information with the psychiatrist.

1. _____ 8. _____
2. _____ 9. _____
   Medication Date Initials
3. _____ 10. _____
   Medication Date Initials
4. _____ 11. _____
   Medication Date Initials
5. _____ 12. _____
   Medication Date Initials
6. _____ 13. _____
   Medication Date Initials
7. _____ 14. _____
   Medication Date Initials

The following topics have been discussed:

- Name and description of the medication
- Potential for interactions
- Risks and benefits
- Expected outcomes
- Potential complications
- Risks and precautions related to driving
- Risks of addictions, withdrawals, and
- Dyskinesia which may be a permanent condition (certain medications)
- Risks of falls and other accidents • Reasonable alternative medications and alternative of NO medication • In females, risks associated with pregnancy and lactation. Please inform us immediately if you become pregnant.
- Risk of concomitant drinking or using other drugs.
- Risk of tardive
- Weight Gain

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I agree and consent to be treated by Teresa Blatt or the covering doctor/nurse practitioner when not available.

I understand and give permission to the office to contact me for appointment reminders, billing/health concerns, and other matters.

I agree to allow the office to via message (text), and/or email me.

I have been given the opportunity to ask questions about the information.

I agree to take the above medications.

I have discussed treatment options in emergency situations with the provider.

_____ _____

PATIENT/LEGAL GUARDIAN SIGNATURE **Today's Date**

_____ _____ **PHYSICIAN**

SIGNATURE **Today's Date**

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Notice of Privacy Practices
Patient Acknowledgement

Patient Name: _____
Date of Birth: _____

I have received this practice's Notice of Privacy Practices which provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how may I exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice.

I understand I can obtain this practice's current notice of Privacy Practice on request.

Signature: _____ Date: _____

Relationship to Patient: _____
(If signed by a personal representative of the patient)