COMPREHENSIVE BEHAVIORAL SERVICES

9021 SHADY GROVE CT. • GAITHERSBURG, MD 20877

MARK J. SMITH, M.D
MICHAEL GROSS, M.D.
PAUL D. FREY, PH.D.

ABBE LEVINE, L.C.S.W.-C
THOMAS REA, L.C.S.W.-C

Patient Information

Patient Name: _____ Today's Date: _____

Street Address: _____

City, State, Zip Code: _____

Home Phone: _____ Cell Phone: _____

Marital Status: _____ Sex: _____ DOB: _____

Social Security Number: _____

Employment: ☐ Full Time ☐ Part Time ☐ Unemployment

Employer's Address and Phone Number: _____

Emergency Contact Information

In Case of an Emergency Please Notify: _____

Phone: _____ Relationship: _____.

Billing Information

Person Responsible for the bill?: _____ Relationship: _____

Do You Have Workers Compensation? ☐ Yes ☐ No

Pre-Authorization #: _____ # of Visits: _____

Primary Insurance: _____ Effective Date: _____

Group #: _____ Subscribers Name: _____

Date of Birth: _____ Relationship: _____

Phone #: _____

Same Address as Patient? ☐ Yes ☐ No

Street Address: _____

City, State, Zip Code: _____

If we need to contact you electronically which would you prefer?

- □ Text message_____
- □ Email _____

Office Policies and Information

Payment is expected at the time of service. The patient is responsible to provide a referral if it is required by your insurance. If a referral is not provided, the patient will be responsible for the total fee incurred. **All appointments and late cancellations are charged as full fee.** Our office will charge medical records reports, medical consultations with other physicians or therapists, medication authorizations, phone calls. Account balance must be paid within 30 days. Payment not made by your insurance company within 90 days from the date of service could turn over to our collection agency.

PLEASE READ AND SIGN

I HEREBY ACKNOWLEDGED THAT I AM FULLY RESPONSIBLE FOR THE PAYMENT OF CHARGES NOT COVERED BY MY INSURANCE (FOR WHATEVER REASON). I CERTIFY FURTHER THAT THE INFORMATION I HAVE PROVIDED IS ACCURATE. I HAVE READ AND AGREE TO FOLLOW THE OFFICE POLICIES REGARDING INSURANCE, THERAPY APPOINTMENTS, ITEMS RETURNED FOR NON-PAYMENT AND PRESCRIPTION REFILL REQUESTS:

SIGNATURE: _____ DATE: _____

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NEW PATIENT QUESTIONAIRE

Patient Name: _____ Date: _____

1. Are you currently seeing a mental health provider (MD, PhD, MSW, NP, certified counselor)? If yes, please supply name of your provider _____

2. If you are not currently seeing a mental health provider have you seen one in the past? If yes please list the problem(s) that required treatment_____
_____

3. Please indicate if you currently have or in the past had any serious medical problems involving:

Heart:	
Lungs:	
Endocrine glands:	
Kidneys:	
Eyes/Vision:	
Hearing:	
Gastrointestinal system:	
Liver/pancreas:	
Blood:	
Nervous system:	
Cancer/Leukemia/lymphoma:	
Skin & extremities:	
Other:	

4. Please list all medications you are currently taking:
_____
_____
_____
_____
_____
_____

5. Please list any drug allergies on serious medication reactions you have had:

My best contact phone number: _____

Is it ☐ OK / ☐ Not OK to leave a message at this number?

Patient Signature: _____ Date: _____

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REVIEW OF SYSTEMS
(INCLUDING SIDE EFFECTS TO MEDICATIONS.)

IF YOU HAVE PROBLEMS WITH ANY OF THE FOLLOWING, CIRCLE EITHER THE SYMPTOM (EXAMPLE: CONSTIPATION) OR THE ORGAN (EXAMPLE: GASTROINTESTINAL).

Patient Name: _____ Date: _____

Constitutional:	Weight gain or loss, BP change, fever, other
Eyes:	Blurred or double vision, dry eyes, photosensitivity
Ears, Nose & Throat	Dry mouth, tinnitus laryngitis, mouth sores
Cardiovascular	Palpitations, slow HR, light headedness, chest pain
Respiratory:	Shortness of breath, tightness, hyperventilation
Gastrointestinal:	Upset stomach, N/V, diarrhea, constipation, blood in the stool, tarry black stools, abdominal pain, incontinence.
Genitourinary:	Hesitancy, frequency, urgency, burring incontinence, changed libido, arousal, or orgasm
Musculoskeletal:	Aches, weakness, numbness, unusual movements, tremors.
Skin/breasts:	Rash, redness, dryness, itching, sweating, change in breast size discharged or milk production
Neurological:	Headache, dizziness, weakness, balance, walking, or falling problems.
Endocrine:	Menstrual changes, hot flushes, changes in hair texture, feeling too hot or too cold when other don't
Hematologic / Lymphatic:	Easy bruising or bleeding, prolonged time for clotting, anemia
Allergic/ immunologic:	Any allergies or sensitivities
Psychiatric:	Anxiety, depression, hallucinations, obsessions, suicidal or homicidal thoughts, phobias, mania/hypomania,
Substance Use:	Tobacco, caffeine, alcohol, other illicit substances (this would also count toward social hx)

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Patient Name: _____ Date: _____

Generalized Anxiety Disorder Scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over 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's 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
Add the score for each column		+	+	+
Total Score (add your column scores) =				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

- ☐ Not difficult at all
- ☐ Somewhat difficult
- ☐ Very difficult
- ☐ Extremely difficult

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Patient Name: _____ Date: _____

Patient Health Questionnaire

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over 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 asleep, 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 you're 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 slowly that other people could have noticed. Or, the opposite – being so fidgety or restless that you 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 some way	0	1	2	3
Add the score for each column	+	+	+	
Total Score (add your column scores) =				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

- ☐ Not difficult at all
- ☐ Somewhat difficult
- ☐ Very difficult

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU GET ACCESS TO THIS INFORMATION, PLEASE REVIEW IT CAREFULLY.

Comprehensive Behavioral service is required by law to maintain the privacy of your health information and to provide you with notice its legal duties and privacy practices with respect to your health information.

How Comprehensive may Use or Disclose Your Health information

Comprehensive collects health information from you and stores it in a chart and a computer This is your medical record. The medical record is the property of Comprehensive, but the information in the medical records belongs to you. Comprehensive protects the privacy of your health information. The law permits Comprehensive to use or disclose your health information for the following purposes.

- □ Treatment.
- □ Payment.
- □ Regular Health Care Operation. This can be waived in cases where the patient did not pay for the service rendered.
- □ Notification and Communication with family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. If you are able and available to agree or object, we will give you the opportunity to object prior to making this notification. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.
- □ Required by law. As required by law, we may use and disclose your health information.
- □ Public health. As required by law, we may disclose your health information to public health authorities for purpose related to: preventing or controlling disease, injury or disability: reporting child abuse or neglect: reporting domestic violence: reporting to the Food and Drug Administration problems with products and reaction to medication: and reporting disease or infection exposure.
- □ Health oversight activities. We may disclose your health agencies during the course of audits, investigations, inspections, licensure and other proceeding.
- □ Judicial and administrative proceedings. We may disclose your health information in the course of any administrative or judicial proceeding.
- □ Law enforcement. We may disclose your health information to law enforcement official for purpose such as identifying of location a suspect, fugitive, material witness or missing person, complying with a court order or subpoena and other law enforcement purposes.
- □ Deceased person information. We may disclose your health information to coroners, medical examiners and funeral directors.
- □ Worker's compensation. We may disclose your health information as necessary to comply with worker's compensation laws.

Acknowledged by:

Date: _____ Signature: _____

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FINANCIAL POLICY

Our goal is to provide and maintain a good physician-patient relationship. We believe that advising you in advance of our policies allows for a good flow of communication. PLEASE READ THIS DOCUMENT CAREFULLY AND INITIAL EACH SECTION. If you have any questions, please do not hesitate to ask a member of our staff. Thank you for choosing our Practice.

FINANCIAL RESPONSIBILITY CONSENT & ASSIGNMENT OF BENEFITS

I hereby accept that I am financially responsible for all services rendered on my behalf by Comprehensive Behavioral Services. For those Insurances from whom the practice accepts assignment, I accept personal responsibility for all co-payments, deductibles, and non-covered services, as indicated by my insurance coverage. I certify that the information I have reported with regard to my insurance coverage is correct. I authorize payment directly to the practice for services for which the Practice accepts assignment.
Initial: _____

MEDICAL RECORDS

I consent to the use and disclosure of my Protected Health Information (PHI) for treatment, payment, and operations and such other purposes that is permitted under the federal Health Insurance Portability and Accountability Act (HIPAA) without written consent.
Initial: _____

INSURANCE COVERAGE

I accept that it is my responsibility to understand my insurance benefit plan. It is my responsibility to know if a written referral or authorization is required to see specialists, whether preauthorization is required prior to undergoing a procedure, and what services are covered. I accept that I am responsible to provide this office with all required information regarding my health insurance coverage. If the insurance company you designate is incorrect, you will be responsible for all unpaid balances. If our physicians do not participate in your insurance plan, payment in full is expected from you at the time of your office visits. In addition it is your responsibility to determine from your insurance carrier what co-payments and deductibles are due. **I accept that co-payments are due at the time of the service.**
Initial: _____

UNINSURED PATIENTS

I accept that if I do not have current health insurance coverage, the entire payment for any services performed shall be paid at the time of service, payable by cash, credit card, or check. Dishonored or returned checks will incur a $35.00 service fee.
Initial: _____

COLLECTION OF OUTSTANDING BALANCES

All outstanding balances shall be due within 30 days, unless we have agreed to other payment arrangements in writing. It is important that you pay all past balances, in their entirety, prior to or at the time of your visit. Balances that remain outstanding for a period of 90 days or more may be referred to a collection agency or an attorney's office. If your account is referred to a collection agency, you will be responsible for paying a collection charge equal to 20% of your outstanding balance, which is in addition to your outstanding balance and any applicable interest. If your account is referred to an outside attorney, you will be responsible for paying all reasonable attorney's fees and court costs, which are in addition to your outstanding balance and any applicable interest.
Initial: _____

PATIENTS RESPONSABILITES

Please do not take our24 hour in advance courtesy appointment call as an opportunity to cancel. [As the LATE CANCELLATION FEE WILL BE APPLIED, in case of NO SHOW]
If the prescription refill is needed prior to your next appointment, there will be a $15.00 fee.
If your prescription needs pre-authorization there will be a $15.00 fee.
Initial: _____

MISSED APPOINTMENTS

We understand that there are times when you must miss a scheduled appointment due to emergencies or other obligation. If you miss a scheduled appointment or cancel the appointment with less than 48 hours' notice, a $50.00 fee for medical management will be billed to you or a $100 fee for full session. Be aware this fee is not covered by your insurance. Additionally, if you have had 2 concurrent late cancellations/no shows, you may be subject to dismissal from the practice.
Initial: _____

RELEASE OF MEDICAL RECORDS

Medical records created by our office shall only be released pursuant to your express written authorization in accordance with HIPPA or other controlling laws (or under other circumstances as required by law). As a courtesy the first copy will be free of charge, for all additional copies, we charge a $35.00 research fee, postage, and a photocopying fee of $0.50 per page up to 50 pages then $0.25 per additional page thereafter.
Initial: _____

By signing bellow, the patient or responsible party acknowledges that he or she has read and understood the foregoing Financial Policy and agrees to be bound by the terms and conditions set forth therein.

Refusal to sign this form may result in our practice not being able to provide services to you, and could result in cancellation of your appointment. If you have any concerns about signing this form, please request to speak directly to our office staff.

_____

Signature of Patient or Responsible Party Date

_____

Print Name of Patient or Responsible Party Date

_____

Print Relationship of Responsible Party Date