Right Track Medical Group
Adult Patient Registration

Patient Name: First: _____ Middle: _____ Last: _____

Preferred Name to be called: _____

How Did you Hear About us: _____

Address: _____
Street City State Zip Code

Phone Number(s): _____
Home Mobile Work Extension

Email Address(s):_____

Marital Status: (circle one) Married Divorced Widowed Single Partnered Legally Separated

Sex: (circle one) Male Female Birth Date: _____ Social Security Number: _____

Guarantor: _____ Relationship to Patient:_____

Address: _____
Street: City: State: Zip Code

Phone Number: _____
Home Mobile Work Extension

Email Address(s):_____

Emergency Contact:_____ Phone:_____

Employer/School:_____Phone:_____

Employer Address:_____
Street City State Zip Code

Insurance Company:_____ Group#:_____ ID#_____

Subscriber:_____ Relationship to Subscriber:_____

Subscriber's Date of Birth: _____ Subscriber's Employer: _____

*Please provide your insurance card and photo ID when you return this form to the receptionist.

Primary Care Provider:_____ Phone:_____

Pharmacy/Location:_____ Phone:_____

Right Track Medical Group

Adult Intake Form

Please complete all information on this form and bring it to the first visit. It may seem long, but most of the questions require only a check, so it will go quickly. You may need to ask family members about the family history. Thank you!

Name_____Date_____

Primary Care Physician_____ Phone: _____

Do you give permission for ongoing regular updates to be provided to your primary care physician? _____

What are the problem(s) for which you are seeking help?

1._____

2._____

3._____

Current Symptoms Checklist: (Mark all that apply)

- ☐ Depressed mood
- ☐ Racing thoughts
- ☐ Excessive worry
- ☐ Unable to enjoy activities
- ☐ Impulsivity
- ☐ Anxiety attacks
- ☐ Sleep pattern disturbance
- ☐ Increased risky behavior
- ☐ Avoidance
- ☐ Loss of interest
- ☐ Increased libido
- ☐ Hallucinations
- ☐ Concentration/forgetfulness
- ☐ Decreased need for sleep
- ☐ Suspiciousness
- ☐ Change in appetite
- ☐ Excessive energy
- ☐ Excessive guilt
- ☐ Increased irritability
- ☐ Fatigue
- ☐ Crying spells
- ☐ Decreased libido

Have you ever had feelings or thoughts that you didn't want to live? ☐ Yes ☐ No.

If YES, please answer the following. If NO, please skip to the next section.

Do you currently feel that you don't want to live? ☐ Yes ☐ No

How often do you have these thoughts? _____

Past Medical History:

Allergies_____ Current Weight _____ Height _____

List ALL current prescription medications and how often you take them: (if none, write none) Medication Name Total Daily Dosage Estimated Start Date

_____
_____
_____
_____

Current over-the-counter medications or supplements: _____
_____

Personal Medical History:

- ☐ Thyroid Disease
- ☐ Anemia
- ☐ Liver Disease
- ☐ Chronic Fatigue
- ☐ Kidney Disease
- ☐ Diabetes
- ☐ Asthma/respiratory problems
- ☐ Stomach or intestinal problems
- ☐ Cancer (type)
- ☐ Fibromyalgia
- ☐ Heart Disease
- ☐ Epilepsy or seizures
- ☐ Chronic Pain
- ☐ High Cholesterol
- ☐ High blood pressure
- ☐ Head trauma
- ☐ Liver problems

Past Psychiatric History:

Outpatient treatment ☐ Yes ☐ No

If yes, please describe when, by whom, and nature of treatment. Reason Dates Treated By Whom

_____
_____
_____

Psychiatric Hospitalization ☐ Yes ☐ No

If yes, describe for what reason, when and where. Reason Date Hospitalized Where

_____

_____

_____

Past Psychiatric Medications:

If you have ever taken any of the following medications, please indicate the dates, dosage and how helpful they were (if you can't remember all the details, just write in what you do remember).

Antidepressants

Prozac (fluoxetine) _____

Zoloft (sertraline) _____

Luvox (fluvoxamine) _____

Paxil (paroxetine) _____

Celexa (citalopram) _____

Lexapro (escitalopram) _____

Effexor (venlafaxine) _____

Cymbalta (duloxetine) _____

Wellbutrin (bupropion) _____

Remeron (mirtazapine) _____

Serzone (nefazodone) _____

Anafranil (clomipramine) _____

Pamelor (nortrptyline) _____

Tofranil (imipramine) _____

Elavil (amitriptyline) _____

Mood Stabilizers

Tegretol (carbamazepine)_____

Lithium_____

Depakote (valproate) _____ _____

Lamictal (lamotrigine) _____

Tegretol (carbamazepine) _____

Topamax (topiramate) _____

Antipsychotics/Mood Stabilizers:

Seroquel (quetiapine) _____

Zyprexa (olanzepine) _____

Geodon (ziprasidone) _____

Abilify (aripiprazole) _____

Clozaril (clozapine) _____

Haldol (haloperidol) _____

Prolixin (fluphenazine) _____

Risperdal (risperidone) _____

Sedative/Hypnotics

Ambien (zolpidem) _____

Sonata (zaleplon) _____

Rozerem (ramelteon)_____

Restoril (temazepam) _____

Desyrel (trazodone) _____

ADHD medications

Adderall (amphetamine) _____

Concerta (methylphenidate) _____

Ritalin (methylphenidate) _____

Strattera (atomoxetine) _____

Antianxiety medications

Xanax (alprazolam) _____

Ativan (lorazepam) _____

Klonopin (clonazepam) _____

Valium (diazepam) _____

Tranxene (clorazepate) _____

Buspar (buspirone) _____

Family Psychiatric History: Has anyone in your family been diagnosed with or treated for:

Bipolar disorder	☐ Yes	☐ No
Schizophrenia	☐ Yes	☐ No
Depression	☐ Yes	☐ No
Post-traumatic stress	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No
Alcohol abuse	☐ Yes	☐ No
Anger	☐ Yes	☐ No
Other substance abuse	☐ Yes	☐ No
Suicide	☐ Yes	☐ No

Is there anything else that you would like us to know?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Signature_____Date_____

By electronically signing this form you agree your electronic signature is the equivalent of your manual/handwritten signature on this form/agreement. You also agree that the electronic signatures appearing on this form/agreement are the same as handwritten signatures for the purposes of validity.

For Office Use Only:

Reviewed by _____Date _____

Right Track Medical Group

E-Sign Consent and Acknowledgment Form

Welcome to Right Track Medical Group. This document contains important information about our services and business policies. We can discuss any questions you have when you sign them or at any time in the future.

Patient Name_____

DOB_____

Consent for Mental Health Services. I voluntarily consent for care encompassing diagnostic procedures and treatment by my physician/nurse practitioner, therapist, his/her assistant, designees or consultants, as may be necessary in the judgement of my physician/nurse practitioner. I also understand that I will be billed direct for those services provided. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made as to the results of treatments or examinations in this clinic. I understand that my medical record may be maintained on a computer-based system and is available to persons involved in my care.

Patient or Responsible Party Initials_____

Authorization to Release. I hereby authorize Right Track Medical Group and any provider caring for me to release or disclose to insurance companies and / or outpatient benefit programs and their designees all information from my medical record pertaining to my medical treatment as needed to process insurance claims.

Patient or Responsible Party Initials_____

Communication: I hereby authorize Right Track Medical Group to communicate with me via voice mail in the event I cannot be reached directly. The phone number on which a voice mail may be left is

_____.

Patient or Responsible Party Initials_____

Release from Responsibility. If I should leave the clinic against medical advice or prior to treatment being completed, I hereby relieve said physicians/ nurse practitioner, therapists and the clinic of all liability for my action.

Patient or Responsible Party Initials_____

Guarantee. Right Track Medical Group is a fee-for-service mental health practice that strives to provide immediate care for patients needing its' services. I understand that I must pay for these services on the date care is rendered. I understand that Right Track Medical Group will file my insurance under out-of-network coverage benefits I may have.

Fee Schedule:

Initial Assessment (1st Appointment) $150
Initial Appointment with Psychiatrist / Nurse Practitioner $350
Follow-up Medication Management $175
Individual Therapy Session $150
Family Therapy Session $250
Group Therapy Session $75

Patient or Responsible Party Initials_____

Assignment of Benefits. I request that any payment of authorized benefits for which I am entitled and which are otherwise payable to me and related to this claim be made on my behalf directly to Right Track Medical Group.

Patient or Responsible Party Initials_____

Cancellation / No Show Policy: If you will arrive 15 minutes past your scheduled time, please call. It may be possible to work you in when an opening arises, accommodate you at the end of the day, or reschedule your appointment. I also understand that if I cancel a scheduled appointment less than 24 hours prior, or if I fail to show for a scheduled appointment, I will be responsible for payment equal to the normal fee for the scheduled service. Patients who no-show or cancel two (2) or more times without 24-hour notice may be required to secure next appointment with a credit/debit card or be dismissed from the practice and thus they will be denied any future appointment(s). Our fee to be charged to you for cancellation/No show is $125.00 and you will be required to pay this fee before another appointment will be made.

Patient or Responsible Party Initials _____

Payment Terms. I understand that payment in full is due on the date of treatment for all services provided, and I agree to pay all charges for the patient named below. If payment in full is delayed for any reason (such as the failure of my insurance to pay the balance in full), I agree to pay the full balance

Patient or Responsible Party Initials_____

Acknowledgment of Receipt of Notice of Privacy Practices. I hereby acknowledge that I have received, read and had an opportunity to ask questions concerning Right Track Medical Group's Notice of Privacy Practices

Patient or Responsible Party Initials_____

I have read and initialed all of the above and I certify that I understand and agree to its content.

_____	_____
Date	Patient or Responsible Party Signature
_____	_____
Date	Staff Witness Signature

Consent to Discuss Treatment

Patient Name: Date of Birth:

_____ _____

First MI Last

Check one:

☐ **I authorize Right Track Medical Group to discuss my treatment with the following individuals I have listed below:** [Please Print]

_____ _____

Name Relationship

_____ _____

Name Relationship

☐ **I do not authorize discussion of my treatment with any individuals.**

_____ _____

Patient Signature Date