PATIENT REGISTRATION FORM

Today's Date: _____ ***Clinic Name*: JYOTI BEHL MD PA**

PATIENT INFORMATION: (Please use full legal name, no nicknames)

***Last Name:** _____ ***First Name:** _____ **Middle Initial:** _____

***Address:** _____

City: _____ **State:** _____ **Zip:** _____

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

***Date of Birth:** _____ **Age:** _____ ***Sex:** _____ **Marital Status:** _____ **Drivers Lic#** _____

***Employer Name and Address:** _____

_____ **Work Phone #:** _____ _____ _____

E-mail Address: _____ **Cell Phone #:** _____ _____ _____

Emergency Contact Name: _____ **Emerg Phone #:** _____ _____ _____

Please tell us how you heard about us: _____ *Referred by:* _____

GUARANTOR INFORMATION: (List person or insured name responsible for bill - use full legal name, no nicknames)

***Last Name:** _____ ***First Name:** _____ **Middle Initial:** _____

***Address:** _____

City: _____ **State:** _____ **Zip:** _____

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

***Date of Birth:** _____ **Age:** _____ ***Sex:** **Female** _____ **Male** _____

***Employer Name and Address:** _____

_____ **Work Phone #:** _____ _____ _____

INSURANCE INFORMATION: (Please allow receptionist to photocopy your insurance ID cards)

IF SOMEONE OTHER THAN PATIENT IS THE INSURED PARTY, PLEASE INCLUDE DATE OF BIRTH FOR CLAIMS

Plan Name: | *Insured's Name:

Insured's Social Security #: | *Insured's Date of Birth:

*Policy/ID #: | *Group #: | Eff Date:

Claims Address & Phone:

SECONDARY INSURANCE:

Plan Name: | *Insured's Name:

Insured's Social Security #: | *Insured's Date of Birth:

*Policy/ID #: | *Group #: | Eff Date:

Claims Address & Phone:

***REQUIRED FIELDS - PLEASE COMPLETE FOR BILLING.** ***ATTACH COPY OF INSURANCE CARDS.**

PATIENT REGISTRATION FORM
DISCLOSURES & CONSENTS

Patient Name: | **Date of Birth:**

First Name | M.L. | Last Name

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize direct payment of my insurance benefits to JYOTI BEHL MDPA or the physician individually for services rendered to my dependents or me by the physician or under his/her supervision. I understand that it ismy responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that JYOTI BEHL MDPA is unable to collect from my insurance carrier for whatever reason.

MEDICARE/MEDICAID/CHAMPUS INSURANCE BENEFITS:

I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependent's records that these programs may request. I hereby direct that payment of my or my dependent's authorized benefits be made directly to JYOTI BEHL MDPA or the physician on my behalf.

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION:

I certify that I have received and read a copy of the JYOTI BEHL MDPA Patient Information Privacy Policy. I hereby authorize JYOTI BEHL MDPA or the physician individually to release any of my or my dependent's medical or incidental non-public personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

AUTHORIZATION TO MAIL, CALL OR E-MAIL:

I certify that I understand the privacy risks of the mail, phone calls, and e-mail. I hereby authorize a JYOTI BEHL MDPA representative or my physician to mail, call or e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying JYOTI BEHL MDPA to that effect in writing.

LAZ/X-RAY/DIAGNOSTIC SERVICES:

I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

CONSENT TO TREATMENT:

I hereby consent to evaluation, testing, and treatment as directed by my JYOTI BEHL MDPA or his or her designee.

PATIENT SIGNATURE: _____ **DATE:** _____

GUARANTOR SIGNATURE: _____ **DATE:** _____

GUARANTOR NAME (Please Print): _____

ATTENTION PATIENTS

OFFICE POLICY FOR JYOTI BEHL MD

1. DR. BEHL DOES NOT CALLS IN PRESCRIPTIONS.
2. Office needs 24 HOURS notice for cancellation of appointments without prior notice Failure to show will result in a charge of $15.
3. Due to patient emergencies extended wait time are possible if this is a problem, *we may not be able to assist you*.

FOR THERAPY PATIENTS ONLY

THERE WILL BE A CHARGE OF $60 IN CASE OF NO SHOW UNLESS APPOINTMENT CANCELLED 48 HOURS AHEAD. THIS IS TOO PAID BEFORE NEXT APPOINTMENT.

NOTES:

- ***A $35 fee will be charged for returned check.***
- ***A $29 fee will be charged for record transfer.***

- ***A $40 fee will be added to any account that is sent to collection.***

Check the box below

☐ * By clicking this box and typing the name below, I am electronically signing my application.

Patient Signature : _____ **DATE:** _____

Print Name: _____

NEW PATIENT QUESTIONAIRE

Patient Name : _____

WHAT IS THE SPECIFIC REASON FOR YOUR VISIT?

_____

_____

_____

Have you seen a counselor, psychologist, psychiatrist or other mental health professional before?

No ☐ **Yes** ☐

If so:

Prior outpatient alcohol / substance abuse treatment

No ☐ **Yes** ☐

If so:

Prior outpatient treatment was successful?

No ☐ **Yes** ☐

Number of prior psychiatrist hospitalization?

_____

Date of last Alcohol/substance abuse treatment?

_____

Involuntary hospitalization in past?

No ☐ **Yes** ☐

PRIOR HISTORY OF NON SUCIDIARY INJURY (SCRATCHING CUTTING BURNING)?

No ☐ **Yes** ☐

Prior history of suicide attempts?

No ☐ **Yes** ☐

If so: ☐

Number of attempts: ☐

Last Attempt: ☐

Method of self-harm: ☐

Attempt resulting in hospitalization **No** ☐ **Yes** ☐

Prior history of aggression or Violance?

No ☐ **Yes** ☐

FAMILY HISTORY

Father: ☐

Age: ☐

Living: ☐

Deceased: ☐

Cause of death: ☐

If deceased, His age at time of his death YOUR age at his time of death

☐

OCCUPATION: ☐

HEALTH: ☐

Frequency of contact with him: Are you/have been close to him?

☐

Mother:

Age:

Living:

Deceased:

Cause of death:

If deceased, His age at time of his death YOUR age at his time of death

OCCUPATION:

HEALTH:

Frequency of contact with him: Are you/have been close to him?

During your childhood, did you live any significant period of time with anyone other than your natural parents?

No **Yes**

If so, please give the person's name and relationship to you

Name:

Relationship to you:

Mood Disorder Questionnaire

Name: **Date:**

Instructions: Complete this questionnaire and give it back to your doctor. Take your time and answer all the questions as best you can.

1. Has there ever been a period of time when you were not your usual self and…

No **Yes** …… you felt so good or hyper that other people thought you were not normal self or you were so hyper that you got into trouble?

No **Yes** …… You were so irritable that you shouted at people or started fights or argument?

No **Yes** …… you felt so much more self-confident than usual?

No ☐ **Yes** ☐	…… you got much sleep than usual and found you didn't really miss it?
No ☐ **Yes** ☐	…… you were much more talkative or spoke much faster than usual?
No ☐ **Yes** ☐	…… thoughts raced through your head or you couldn't slow your mind down?
No ☐ **Yes** ☐	…… you were so easily distracted by things around you that you had trouble concentrating or staying on track?
No ☐ **Yes** ☐	…… you had more energy than usual?
No ☐ **Yes** ☐	…… you were much more active or did many more things than usual?
No ☐ **Yes** ☐	…… you were much more social or outgoing than usual; for example, you telephoned friends in the middle of the night?
No ☐ **Yes** ☐	…… you much more interested in sex than usual?
No ☐ **Yes** ☐	…… you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?
No ☐ **Yes** ☐	…… spending money got you or family into trouble?

Questionnaire Part A | Self Evaluation

Patient's Name: _____ **Date:** _____

Instructions: The questions below are designed to help your doctor evaluate patients with anxiety symptoms. Keep in mind, a high score on this questionnaire does not necessarily mean that you have an anxiety disorder - only an evaluation by a physician can make a determination. Answer the questions below as accurately as you can; these will help your doctor make a diagnosis.

Please circle YES or NO for the following questions, based on your experience in the past MONTH:

Have you been bothered by unpleasant thoughts or images that repeatedly enter your mind, such as:

1. Concern with contamination (dirt, germs, chemicals, radiation) or acquiring a Serious illness such as AIDS? No ☐ Yes ☐

2. Over concern with keeping objects (clothing, groceries, and tools) in perfect order or arrange exactly? No ☐ Yes ☐

3. Images of death or other horrible events? No ☐ Yes ☐

4. Personally unacceptable religious or sexual thoughts? No ☐ Yes ☐

Have you been worried a lot about terrible things happening, such as?

5. Fire, burglary or flooding of the house? No ☐ Yes ☐

6. Accidently hitting a pedestrian with your car or letting it roll down a hill? No ☐ Yes ☐

7. Spreading an illness (giving someone AIDS)? No ☐ Yes ☐

8. Losing something valuable? No ☐ Yes ☐

9. Harm coming to loved one because you weren't careful enough? No ☐ Yes ☐

Have you been worried about acting on an unwanted and senseless urge or impulse, such as?

10. Physically harming a loved one, pushing a stranger in front of a bus, steering your cart into oncoming traffic; inappropriate sexual contact; or poisoning dinner guests? No ☐ Yes ☐

Have you felt driven to perform certain acts over and over again, such as?

11. Excessive or ritualized washing, cleaning or grooming? No ☐ Yes ☐

12. Checking light switches, water faucets, the stove, door locks or the emergency brake? No ☐ Yes ☐

13. Counting; arranging; evening-up behaviors (making sure socks are at the same height)? No ☐ Yes ☐

14. Collecting useless objects or inspecting the garbage before it thrown out? No ☐ Yes ☐

15. Repeating routines actions (in/out of chair, going through doorway, relighting cigarette)?	**No** ☐	**Yes** ☐
16. Needing to touch objects or people?	**No** ☐	**Yes** ☐
17. Unnecessary rereading or rewriting; reopening envelopes before they are mailed?	**No** ☐	**Yes** ☐
18. Examining your body for signs of illness?	**No** ☐	**Yes** ☐
19. Avoiding colors ("red" means blood), numbers ("13" is unlucky) or names (Those that start with "D" signify death) that is associated with dreaded events or Unpleasant thoughts?	**No** ☐	**Yes** ☐
20. Needing to "confess" or repeatedly asking for reassurance that you said or did something correctly?	**No** ☐	**Yes** ☐

Patient Self - Evaluation

Instruction: The following questions refer to the repeated thoughts, images, urges or behaviors identified in Part A. Consider your experience during the past 30 days when selecting an answer.

	0 None	**1 Mild(less than 1 hour)**	**2 Moderate(1 to 3 hours)**	**3 Severe(3 to 8 hours)**	**5 Extreme(more than 8 hours)**
1. On average how much time is occupied by those thoughts and behaviors?	☐	☐	☐	☐	☐
2. How much distress do they cause you?	☐	☐	☐	☐	☐
3. How hard it is for you to control them?	☐	☐	☐	☐	☐
4. How much do they cause you to avoid doing anything, going anywhere or being with	☐	☐	☐	☐	☐

anyone?					
5. How much do they interfere with school, work or your social or family life?	☐	☐	☐	☐	☐

PLEASE BRING THE FOLLOWING ON YOUR VISIT:

1. **BRING ALL THE LAB RESULTS AND MR IF ADMITTED AT THE HOSPITAL**
2. **CURRENTLY TAKING RX BOTTLES OR MEDICATIONS AND DOSAGE LIST**
3. **IF THE PATIENT IS A MINOR NEED TO BE SEEN WITH PARENTS FREELY AVAILABLE TO PROPERLY EVALUATE THE PATIENT.**
4. **PLEASE NO LITTLE KIDS**
5. **PLEASE CALL YOUR INSURANCE AND ASK FOR YOU CO-PAY BEFORE YOUR VISIT.**