New Patient Information sheet

PATIENT NAME _____ AGE _____ DOB _____ GENDER: M F

PARENT NAME (If Applicable) _____ Outside Benton/Washington YES NO

ADDRESS _____
City State Zip

PRIMARY PHONE #: _____ (HOME/WORK/CELL) SECONDARY PHONE #: _____ (HOME/WORK/CELL)

EMAIL ADDRESS: _____

REFERRING PROVIDER: _____ PCP: _____

INSURANCE NAME: _____ POLICY ID NUMBER: _____ GROUP #: _____

POLICY HOLDER NAME: _____ DOB: _____

What are the concerns for you/your child, that you would like the doctor to address? Anxiety Depression Medication Management Behavior Issues

Other concerns/goals: _____

Are there any other questions or concerns regarding you/your child's mental health that you would like addressed?

_____

Have you been hospitalized for psychiatric needs in the past 2 months? YES NO

If yes, when and where? _____ Duration of stay: _____
Medical records will need to be provided, please contact the hospital to release records to us.

Do you presently take any of the following medications: **Xanax, Valium, Ativan, Klonopin?** YES NO

If yes, please be advised our doctor's typically do not prescribe those medicines and they may not be continued based on the sole discretion of the physician.

For adults over 18, are you looking for ADHD treatment? YES NO

If yes, we will need the results of the psychological evaluation before scheduling can occur. **WE DO NOT DO TESTING for ADHD. Testing needs to be done prior to your visit from a psychologist.** If testing has been done, results of those tests will be needed for your first visit.

Are you/your child looking for treatment related to substance abuse such as; opiates, benzodiazepines, methylamphetamines, marijuana, Alcohol?
YES NO **If yes, we do not provide outpatient services for substance related dependency.**

This practice does not provide evaluations or screenings for the use of medical marijuana or to obtain a medical marijuana card.

Are you transferring care from another provider? YES NO Provider Name: _____
If yes, we would prefer to have medical records from the previous provider before scheduling occurs, but definitely before the first appointment.

If you must cancel your appointment, please do so greater than 48 hours before the appointment. Not doing so will result in a charge of $75 which will need to be paid before the consultation can be rescheduled.

Please arrive 30 minutes before your appointment if paperwork is not completed ahead of time. If you do not come early to fill out paperwork, your appointment may be cancelled. The doctor will complete an evaluation with you/your child to determine your mental health care needs. If further evaluations or records are needed, medications may not be prescribed on the first visit.

Northwest Arkansas Psychiatry a MANA Clinic
4700 S. Thompson Suite C-103
Springdale, AR 72762
479.571.6363

Clinic Information:
NWA Psychiatry a MANA clinic provides care for adults and children. Our goal is to provide you with support and education. **Our psychiatrists provide ongoing medication management.** We will recommend ongoing counseling or therapy as needed.

Appointments, cancellations and missed appointment policy:
NWA Psychiatry requires a minimum of 24 hours' notice of cancellation prior to the scheduled appointment. Therefore, cancellations with less than 24 hours' notice will incur a $25 fee. Please be advised that insurance companies will NOT reimburse for missed appointments fees. All appointments are scheduled for a specific block of time. **If you arrive later than 7 minutes for your scheduled appointment, your appointment will have to be reschedule.** Please be aware that keeping your appointment is necessary for medication refills (see medication refill policy)

Failure to attend the initial appointment may forfeit future visits and you will be billed $75. Your initial appointment visit will NOT be rescheduled until this fee is paid in full.

In the event of inclement weather please call to confirm your appointment before attending.

Termination policy:
After THREE missed appointments without providing notice could result in termination from this practice. We also reserve the right to terminate for noncompliance.

Medication refill policy:
Medication refills coincide with when you are expected back for an appointment however, there might be circumstances in which a refill would be needed before your next scheduled appointment. Refill requests will require **AT LEAST 72 HOURS (3 DAYS) notice to process.** Faxed requests from the pharmacy WILL NOT be processed. YOU are required to call the office to request your refill. **Not keeping follow up appointments could result in a disruption of your medication regimen.**

Insurance plans and financial policy:
NWA Psychiatry is a mental health provider and may be out of network with some insurance companies when other MANA clinic providers are in network. Our current out of network list includes, Cigna, Humana Military (Tricare), Magellan as well as many of the Medicare replacement plans. It is important to note that some insurance policies do not cover mental health care and it is your responsibility to check your benefits. Please remember that your insurance policy is a contract between you and the insurance provider; therefore, the clinic cannot guarantee payment of your claim(s) and must render the patient responsible for any services not covered by insurance.

Signature:_____ Date:_____

Patient Name (PRINT):_____ Date of birth:_____

4700 S. Thompson, Ste. C-103
Springdale, AR 72764

Phone: (479) 571-6363

Fax: (479) 684-3941

www.mana.md

NWA PSYCHIATRY
a MANA clinic

LANCE C. FOSTER, M
Child, Adolescent, & Adult Psychia

RANDALL STALEY JR., M
Child, Adolescent, & Adult Psychia

BRITTANY BISHOP SEIFERT, APR
Psychiatric Mental Health Nurse Practitior

CHILD/ADOLESCENT INTAKE FORM

CHILD'S NAME: _____ TODAY'S DATE: _____

DATE OF BIRTH: _____ RACE: _____ SEX: _____

OTHER NAME YOUR CHILD PREFERS TO BE CALLED: _____

NAME OF PERSON COMPLETING FORM: _____

RELATIONSHIP TO CHILD: _____

WHO REFERRED YOU TO OUR CLINIC: _____

MAY WE CONTACT THEM: _____ YES _____ NO

PRIMARY CARE DOCTOR: _____

MAY WE CONTACT THEM: _____ YES _____ NO

PRIMARY CONCERNS FOR CONSULTATION: _____

_____

_____

HOW LONG HAVE THESE CONCERNS BEEN PRESENT: _____

WHAT ARE YOUR GOALS FOR TREATMENT: _____

_____

_____

WHICH OF THE FOLLOWING SYMPTOMS/CONCERNS HAS YOUR CHILD EXPERIENCED IN THE LAST 60 DAYS:

_____ Sad or depressed mood _____ Withdrawn from family or friends

_____ Loss of interest in activities or hobbies _____ Feelings of guilt or worthlessness

_____ Feeling hopeless about the future _____ Sleep disturbance _____Change in appetite

_____Low energy or fatigue _____Trouble focusing or concentrating _____Thoughts of hurting self

_____Thoughts of suicide _____Thoughts of hurting or killing others _____Irritability

_____Severe angry outbursts (verbal or physical) _____Worrying too much

_____Feeling or acting restless _____Muscle tension _____Panic or anxiety attacks

_____Fear of looking stupid or being embarrassed _____Fear of offending others

_____Any other fears or phobias _____Drastic mood swings _____Episodes of decreased need for sleep

_____Extreme hyperactivity _____Racing thoughts _____Talking so fast it's hard to understand

_____Overly happy or euphoric _____Overly confident

_____Thoughts, feelings or images that come into the child's mind when he/she does not want them to?

_____Habits the child feels they must do even if he/she knows it does not make sense (for example excessive cleaning, checking, repeating, counting, organizing or hoarding things)?

_____Hearing voices that other people cannot hear _____Odd thinking or beliefs

_____Seeing things other people cannot see _____Feeling paranoid _____Poor body image

_____Trying to lose weight even though he/she is not overweight

_____Intentionally throwing up after eating _____Easily loses temper _____Easily annoyed

_____Defiant _____Argues with authority figures _____Annoying others on purpose

_____Blaming others for his/her mistakes _____Resentful, spiteful or vindictive _____Lying

_____Stealing _____Destroying property _____Setting fires _____Skipping school

_____Hurting other people or animals _____Difficulty learning

_____Trouble understanding social cues _____ Difficulty making/keeping friends

_____Sensitive to sound, light, touch or smell

HAS YOUR CHILD EXPERIENCED A TRAUMATIC EVENT: _____ Sexual abuse _____ Physical abuse

_____ Near death experience _____ Other traumatic event: _____

_____

SOCIAL HISTORY:

WHO LIVES AT THE CHILD'S PRIMARY RESIDENCE: _____ Mom _____ Dad _____Brother(s)

_____ Sister(s) _____ Step-parent _____ Grandmother _____ Grandfather _____ Aunt _____ Uncle

_____ Cousin(s) _____ Foster parent(s) _____ Foster sibling(s)

_____ Other: _____

IS THE CHILD ADOPTED? _____ YES _____NO IS THE CHILD AWARE? _____ YES _____NO

CURRENT SCHOOL: _____ GRADE: _____

DOES YOUR CHILD HAVE AN IEP OR 504 PLAN? _____ YES _____NO. If yes, please bring a copy to the first visit.

ARE THERE CURRENT BEHAVIOR CONCERNS AT SCHOOL? _____ YES _____NO

IF YES, PLEASE EXPLAIN: _____

_____

_____

HAS YOUR CHILD BEEN SUSPENDED OR EXPELLED FROM SCHOOL? _____ YES _____NO

ARE THERE ANY CURRENT LEGAL PROCEEDINGS INVOLVING THE CHILD? _____ YES _____NO

IF YES, PLEASE EXPLAIN: _____

_____

_____

PREGNANCY HISTORY:

WAS THE PREGNANCY COMPLICATED BY ANY OF THE FOLLOWING, PLEASE EXPLAIN ANY YES ANSWER:

Preterm labor _____ YES _____NO _____

Substance abuse _____ YES _____NO _____

Emotional problems _____ YES _____NO _____

Medications _____ YES _____NO _____

Medical problems _____ YES _____NO _____

HOW MANY WEEKS GESTATION WAS THE PREGNANCY? _____ Weeks, _____Term, _____ Preterm

WAS THE DELIVERY (CHECK ALL THAT APPLY): _____ Vaginal _____C-Section _____ Induced

_____Spontaneous _____ Scheduled _____Emergent

ANY DELIVERY COMPLICATIONS? _____ YES _____NO. If yes, please explain: _____

_____

DEVELOPMENTAL HISTORY:

WERE EARLY CHILDHOOD DEVELOPMENTAL MILESTONES (SIT, WALK, TALK, TOILET TRAIN, ETC)?

_____Early _____On time _____Late

PLEASE LIST ANY DEVELOPMENTAL CONCERNS ABOUT YOUR CHILD: _____

_____

_____

PAST MEDICAL HISTORY:

HAS YOUR CHILD EVER HAD? _____ Headaches _____Seizures _____ Allergies (seasonal)

_____Diabetes _____ Thyroid condition _____Asthma _____ Other lung problems _____Cancer

_____ Head injury/concussion _____OTHER:_____

_____

HAS YOUR CHILD EVER HAD ANY SURGERIES? _____ YES _____NO If yes, please list surgeries and dates:

_____

_____

_____

_____

CURRENT MEDICATIONS

Name	Dosage	Frequency	When started

MEDICATION ALLERGIES _____ NONE _____YES (please explain) _____

_____

OTHER ALLERGIES _____ NONE _____YES (please explain) _____

_____

BIOLOGICAL FEMALES ONLY: HAS YOUR CHILD STARTED MENSTRUATION? _____ YES _____NO

IF YES, AT WHAT AGE _____

ARE PERIODS REGULAR? _____ YES _____NO DATE OF LAST MENSTRUAL CYCLE ____ / ____ / _____

IS THERE ANY CHANGE IN SYMPTOM SEVERITY WITH PERIODS? _____ YES _____NO

IF YES, PLEASE DESCRIBE_____

PAST PSYCHIATRIC HISTORY:

HAS YOUR CHILD EVER SEEN A PSYCHIATRIST OR THERAPIST/COUNSELOR BEFORE? ____ YES _____NO

Name of provider Dates seen Reason

_____

_____

_____

_____

HAS YOUR CHILD EVER BEEN ADMITTED TO A PSYCHIATRIC HOSPITAL? _____ YES _____NO

Name of the hospital Dates Reason

_____

_____

_____

_____

HAS YOUR CHILD EVER ATTEMPTED SUICIDE? _____ YES _____NO If yes, please describe: _____

_____

_____

DOES YOUR CHILD ENGAGE IN ANY SELF-HARM BEHAVIORS (LIKE CUTTING)? _____ YES _____NO

If yes, please describe: _____

_____

_____

HAS YOUR CHILD EVER BEEN VIOLENT OR AGGRESSIVE? _____ YES _____NO

If yes, please describe: _____

_____

_____

HAS YOUR CHILD EVERY USED ANY OF THE FOLLOWING? (MARK ALL THAT APPLY)

_____Tobacco _____Vaping _____Marijuana _____Alcohol

_____Opiates _____Benzos _____Ecstasy _____Methamphetamine

_____Cocaine _____Heroin _____Other:_____

IS YOUR CHILD CURRENTLY USING ANY OF THOSE MARKED ABOVE? _____Yes _____No

PLEASE MARK ANY PSYCHIATRIC MEDICATIONS YOUR CHILD HAS TAKEN IN THE PAST:

_____Alprazolam (Xanax) _____Diazepam (Valium) _____Mirtazapine (Remeron)

_____Amitriptyline (Elavil) _____Duloxetine (Cymbalta) _____Nortriptyline (Pamelor)

_____Amphetamine (Adderall) _____Escitalopram (Lexapro) _____Olanzapine (Zyprexa)

_____Aripiprazole (Abilify) _____Fluoxetine (Prozac) _____Oxcarbazepine (Trileptal)

_____Asenapine (Saphris) _____Fluphenazine (Prolixin) _____Paliperidone (Invega)

_____Atomoxetine (Strattera) _____Fluvoxamine (Luvox) _____Paroxetine (Paxil)

_____Bupropion (Wellbutrin) _____Guanfacine (Intuniv) _____Quetiapine (Seroquel)

_____Buspirone (BuSpar) _____Haloperidol (Haldol) _____Risperidone (Risperdal)

_____Carbamazepine (Tegretol) _____Iloperidone (Fanapt) _____Sertraline (Zoloft)

_____Citalopram (Celexa) _____Imipramine (Tofranil) _____Topiramate (Topamax)

_____Clomipramine (Anafranil) _____Lamotrigine (Lamictal) _____Trazodone (Desyrel)

_____Clonazepam (Klonopin) _____Levomilnacipran (Fetzima) _____Valproic Acid (Depakote)

_____Clonidine (Kapvay) _____Lisdexamfetamine (Vyvanse) _____Venlafaxine (Effexor)

_____Clozapine (Clozarli) _____Lithium _____Vilazodone (Viibryd) _____Desipramine (Norpramin)

_____Lorazepam (Ativan) _____Vortioxetine (Brintellix) _____Desvenlafaxine (Pristiq)

_____Loxapine (Loxitane) _____Ziprasidone (Geodon) _____Dexmethylphenidate (Focalin)

_____Lurasidone (Latuda) _____ Other: _____

FAMILY MEDICAL HISTORY including great grandparents, grandparents, parents, great aunts, great uncles, aunts, uncles, cousins of any degree, siblings, nieces, nephews, etc.

Have any of your child's relatives ever had any of the following:

	Yes	No	Relationship to child
Migraine/Chronic headaches			
Seizures			
Stroke			
High blood pressure			
Heart disease			
Heart attack			
Heart Murmur			
Lung disease			
Asthma			
Gastric reflux disease			
Diabetes			
High cholesterol			
Liver disease			
Kidney disease			
Thyroid disease			
Obesity			
Glaucoma			
Anemia			
Sudden unexplained death			
Dementia			
Cancer			

FAMILY PSYCHIATRIC HISTORY

Have any of your child's blood relatives ever had any of the following:

	Yes	No	Relationship to child
Depression			
Bipolar disorder			
Suicide			
Anxiety disorders			
Panic disorder			
Agoraphobia			
Obsessive Compulsive Disorder			
PTSD			
Eating disorder			
Schizophrenia			
Other psychosis			
ADHD/ADD			
Oppositional Defiant Disorder			
Conduct disorder			
Personality disorders			
Tourette's syndrome			
Autism spectrum disorder			
Alcoholism			
Substance abuse			
Psychiatric hospitalizations			

Signature of person completing form

Date

AUTHORIZATION TO RELEASE INFORMATION

Patient Name_____Date of Birth_____

Caregiver Name(s)_____Relationship to Patient_____

Telephone (Home)_____(Work)_____

Email Address_____

Home Address_____

City_____State_____Zip_____

I request and authorize the release of medical information from:

□PrimaryCareProvider_____

Clinic_____Phone_____Fax_____

□Therapist or Counselor_____

Clinic_____Phone_____Fax_____

□Other Provider_____

Clinic_____Phone_____Fax_____

Release my records to:

Northwest Arkansas Psychiatry, a MANA clinic
4700 S. Thompson Suite C-103
Springdale, AR 72764
(479)571-6363 (phone) (479)684-3941(fax)

Please specify which records/information you would like released:

□All Records (including) □Clinic Notes □Laboratory □Mental Health □Substance Use □Pain Contract

By signing below I understand that:

I may revoke this authorization at any time. In signing this form, I am authorizing the release of my protected health information. I understand that upon my release this health information is no longer protected and has the potential to be re-disclosed by the recipient. Treatment will not be denied to me if I do not sign this form. The authorization expires one year from the date of this signature.

Signature_____Date_____

Completed packets can be returned in the following ways:

IN PERSON or MAILED to:

NW AR Psychiatry
4700 S Thompson
C-103
Springdale, AR 72764

FAX:
479.684.3941

EMAIL:
psychiatry@mana.md

Please feel free to call our office with any questions
479.571.6363

Patient Name _____ D.O.B. _____

PERSON RESPONSIBLE FOR PAYMENT

Responsible Party _____ DOB _____

Relationship to Patient _____ SS# _____

Phone _____ Address _____ City _____ State ____ Zip _____

HEALTH INSURANCE INFORMATION

Please provide a copy of your insurance card to the receptionist.

MEDICARE ☐ Medicare No. _____ - _____ - _____ - _____ Effective Date _____

PRIMARY INSURANCE _____

ID# _____ GP# _____ Phone# _____

Policy Holder's Name _____ DOB _____ SS# _____

Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Step-Child ☐ Other

SECONDARY INSURANCE _____

ID# _____ GP# _____ Phone# _____

Policy Holder's Name _____ DOB _____ SS# _____

Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Step-Child ☐ Other

PATIENT AUTHORIZATION

I hereby authorize Medical Associates of Northwest Arkansas {MANA), in its sole discretion, to seek payment of charges for all services rendered during or in connection with my medical treatment from my insurer and/or from third parties {or their insurers} who may have caused, or otherwise be liable for, the incident, injury or condition giving rise to my need for medical treatment. I understand that in the event MANA attempts to collect from those third parties, such attempts are in lieu of, or in addition to, MANA seeking payment from my current medical insurance provider. I understand and agree that any discounts which MANA has agreed to accept from my medical insurance provider will not be applied to reduce amounts payable by, or recoverable from, third parties or their insurers.

I hereby assign and authorize payment directly to MANA of all insurance benefits, sick benefits and injury benefits due because of liability of a third party and proceeds of all claims resulting from the liability of a third party to me or for my benefit unless all charges are paid in full immediately upon completion of my medical treatment. I further agree that this assignment will not be withdrawn at any time until the account is paid in full and consent to MANA's assertion of subrogation or lien rights, if necessary, to protect MANA's interest in recovering from third parties the full amount of charges for services rendered during or in connection with my medical treatment.

I agree to pay at the time of service any co-pay or amount otherwise required by my current medical insurance provider and understand that I am responsible for any amount not covered by Insurance or collected by MANA from a third party. MANA Is authorized to give information regarding me, my case and my medical treatment to my current medical Insurance provider and/or to potentially financially responsible third parties and their insurers.

SIGNATURE _____ **DATE** _____

Authorization For Release of Protected Health Information

I, _____ give all physicians and professional staff employed by Medical Associates of NWA, PA, permission to disclose the protected health information set forth below to the following people at the request of one or more of these individuals.

Patient name (print): _____ **D.O.B.** _____

Information to be released to the below referenced entity:

☐ **Complete Medical Record**
☐ **Seek Medical Care**
☐ **or specific information:** _____

PLEASE PRINT: **NAME** **RELATIONSHIP TO PATIENT**

_____

_____

_____

I give Medical Associates of Northwest Arkansas P.A., permission to:

- Fax my child's School Excuse to his/her school.
  ☐ **Yes** ☐ **No**
- Leave a message (s) on my answering machine if they should need to remind me of an appointment, change an appointment, etc, and are unable to reach me in any other way.
  ☐ **Yes** ☐ **No**

In addition, I understand or acknowledge the following:

1. I understand that Medical Associates of Northwest Arkansas, P.A ., will not release any information to any person(s) not listed above.
2. I have the right to revoke this Authorization at any time by giving Medical Associates of Northwest Arkansas, P.A., a written notice. I understand this does not apply to the release of PHI pursuant to my prior authorization.
3. I have received Medical Associates of Northwest Arkansas's Notice of Privacy Practices
4. My protected health information may be subject to re-disclosure by one or more of the persons named above and as such may no longer be protected by federal or state law.
5. My treatment is not conditional on signing this statement, except as allowed by Privacy Rule.

This authorization shall expire on the _____ day of _____, 20_____ and/or the following **Event**_____

Patient Signature:_____**DATE:**_____

In the event the Authorization is being executed by a personal representative, guardian, or parent, please print your name, relationship to the patient, and basis of authorization to act on the patient's behalf.

Print name _____**Relationship to Patient**_____

What is your authorization to act on the patient's behalf?_____

Signature _____ **Date** _____

Revised 5/22/14 cbm

mana
medical associates