My Mental Health LLC
1600 Crain Hwy S Ste:503
Glen Burnie, MD 21061
Ph: 443.354.1200 • Fax: 410.553.0019

Patient Information

Patient Name: ____
Last First Middle Initial

Prior Last Names: ___________________________ Race: African American Asian Caucasian
Hispanic Native American Other

Social Security Number: ______ - _______ - _______ Date of Birth: ________/________/______
Sex: M or F Marital Status: Single Married Divorced Widow Separated

Mailing Address: ____

City: ______________________________ State: _________ Zip: _______________________

Phone: __________________________________ Cell / Other: __________________________________

Insurance Information

Name of Primary Insurance: ______________________ Policy ID Number: ___________________________

Subscriber Name: ________________________________ Subscriber DOB: _______ / ______ / _______

Subscriber Social Security #: ______- _______ - ________ Relation to patient: _________________

Group Number: _____________________ Subscriber Employer / Group Name: _____________________

Subscriber work status: FT PT Retired

(Please fill out secondary insurance if applicable)

Name of Primary Insurance: ______________________ Policy ID Number: ___________________________

Subscriber Name: ________________________________ Subscriber DOB: _______ / ______ / _______

Subscriber Social Security #: ______- _______ - ________ Relation to patient: _________________

Group Number: _____________________ Subscriber Employer / Group Name: _____________________

Subscriber work status: FT PT Retired

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Emergency Contact Information:

Person to notify / Next of Kin: ____
Last First MI

Mailing Address: ____

City: _______________________________ State: _________ Zip: _____________

Phone: _________________________________ Relationship to patient: ___________________________

Protected Health Information:

For confidentiality reasons, family member phone calls about treatment will not be returned. I must request my family and or specified individual to join me as part of my appointment if I wish to include them in my care. I know and agree to the charges provided to me by My Mental Health LLC if they do join me during my appointment.

Therefore I, ________________________________, give *My Mental Health LLC*. Permission to make and disclose the following with the person listed below:

☐ Scheduling / Canceling appointments
☐ Medication questions
☐ Speak with the provider regarding patient (*Only in appointment*)

Name: ___________________________________ Phone: _____________________________

Relation: _________________________________

Conformation Calls:
How would you like to receive your appointment conformation?

☐ Call

☐ Text

☐ Opt out

Note: We cannot do both.

Current Medication and Allergies:

What daily / weekly medications are you currently taking?

____

____

Have you or are you currently taking any psych medication? *(if 'Yes' please list below)* ☐ YES ☐ NO

____

____

Do you have allergies to medication? *(if 'Yes' please list below)* ☐ YES ☐ NO

____

____

Current Concerns – Please **CIRCLE** one or more of the following items:

Anxiety/Worry/Nervousness	Thoughts of harming yourself
Sadness/Depression	Thoughts of harming others
Anger/Temper	Low self-esteem
Irritability	Paranoia/Suspiciousness
Sleep Difficulty	Hearing voices/noises
Change in appetite/weight	Seeing visions
Loss of pleasure in activities	Panic attacks
Concentration difficulties	Racing thoughts
Memory lapses	Recurring, unwanted thoughts
Low motivation	Alcohol or other substance use
Mood swings	Loneliness

Impulsivity | Risk-taking behavior

Nightmares | Flashbacks

Binge eating | Restrictive eating

Other: ____

Sources of stress – Please **CIRCLE** one or more of the following items:

Health	Family	Finances
Work	Relationships	Loss
School	Physical appearance/body image	Housing

Other: ____

Psychiatric History:

#	Question		
1.	Have you ever been evaluated by a psychiatrist before?	Yes	No
2.	Have you ever been in psychotherapy (talk therapy) before?	Yes	No
3.	Have you ever been hospitalized on a psychiatric unit?	Yes	No
4.	Have you ever attempted to end your life?	Yes	No
5.	Have you ever been aggressive or violent towards others?	Yes	No
6.	Have you ever been treated for an alcohol or drug abuse problem?	Yes	No
7.	Have you ever been prescribed medication for a mental health condition?	Yes	No
8.	Does any family member have a mental illness? (If yes, please specify relative in the space provided)	Yes	No

☐ Bipolar disorder:

☐ Post-traumatic Stress disorder:

☐ Major depression:

☐ Schizophrenia:

☐ Anxiety disorder:

☐ ADHD:

☐ Panic disorder:

☐ Drug/Alcohol dependence:

☐ Obsessive Compulsive Disorder (OCD):

Psychosocial History:

1. Place of birth: ____
2. Any history of birth complications or developmental delays? Yes No
   If yes, please specify: ____
   ____
3. My childhood was (please circle):
   Very Happy Happy Fair Unhappy Very unhappy
4. History of abuse (circle): None Verbal Emotional Physical Sexual
5. Marital Status (Please circle): Single Married Separated Divorced Widowed Partnered
6. With whom do you live? ____

7. Do you have any children? Yes No (If yes, list ages: ____________________________)
8. Religion/Spiritual beliefs: ____
9. Military service: ____
10. Occupation: ____
11. Past employment: ____
12. Highest level of education? ____
13. History of arrests or other legal issues? Yes No

Substance Use History: Please **CIRCLE** one or more of the choices provided

Caffeine	Current	Past	Never
Alcohol	Current	Past	Never
Nicotine	Current	Past	Never
Marijuana	Current	Past	Never
Cocaine	Current	Past	Never
Amphetamines/Stimulants	Current	Past	Never
Hallucinogens (ex. PCP, LSD, mushrooms)	Current	Past	Never
Opiates (ex. Heroin, oxycodone)	Current	Past	Never
Sedatives (ex. Valium, Xanax)	Current	Past	Never

Alcohol History:

1. How many drinks can you hold without feeling drunk? __________
2. Have you ever felt that you should cut down on your drinking? Yes No
3. Have close friends or family members ever told you about things you said or did while you were drinking that you could not remember? Yes No
4. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? Yes No
5. Have you ever had a DWI? Yes No

I verify that all information provided above is complete and accurate to my knowledge.

X______________________________ ____/______/__________
Patient signature Date

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Suicide Risk Assessment:

Have you ever had feelings or thoughts that you didn't want to live? [ ] Yes [J No

If YES, please check and answer the following. If NO, please skip.

☐ Do you currently feel that you do not want to live? [ ] Yes [ ]No

☐ How often do you have these thoughts? ____

☐ When was the last time you had thoughts of dying? ____________________________________

☐ Has anything happened recently to make you feel this way? ______________________________

☐ On a scale of 1-10 (ten being the strongest) how strong is the desire to kill yourself currently? ___________

☐ Would anything make it better? ____

☐ Have you ever thought about how you would kill yourself?
____

☐ Is the method you would use readily available?
____

☐ Have you planned a time for this?
____

☐ Is there anything that would stop you from killing yourself? ___________________________________

☐ Do you feel hopeless and/or worthless?
____

☐ Have you ever tried to kill or harm yourself before?
____

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PATIENT HEALTH QUESTIONAIRE (PHQ -9)

Name: ____________________________________ Date: _________________________

Over the last 2 weeks, how often have you been
Bothered by any of the following problems?
(use "X" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly Everyday
1. Little interest or pleasure in doing things	0	1	2	3
2. Felling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping to much	0	1	2	3
4. felling 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 are a failure or have let yourself or 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 so slowly that other people could have noticed or the opposite being so fidgety or restless that you have been moving around a lot more then usual	0	1	2	3

9. Thoughts that you would be better off dead or of hurting yourself	0	1	2	3
Total				

Add Columns ______ + ______ + ______+ _______ = _____________

Healthcare professional: For interpretation of TOATAL, please refer to accompanying scoring card)

10. If you checked off any problems, how difficult have these problems 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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My Mental Health, LLC

Statement of Patient Financial Responsibility

Patient Name: _______________________________________ DOB:

My Mental Health, LLC appreciates the confidence you have shown in choosing us to provide for your mental health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

I have read the above policy regarding my financial responsibility to My Mental Health, LLC, for providing services to me or the above-named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to My Mental

Health, LLC the full and entire amount of bill incurred by me or the above-named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

Patient Signature ______________________________________ Date _____________________

Guarantor Signature __________________________________ Date _____________________
(If guarantor is not the patient)

Co-Pay Policy

Some health insurance carriers require the patient to pay a co-payment for services rendered. It is expected and appreciated at the time the service is rendered for the patients to pay at EACH VISIT. Thank you for your cooperation in this matter.

Patient/Guarantor Signature ______________________________________ Date _________________

Consent for Treatment and Authorization to Release Information

I hereby authorize My Mental Health, LLC, through its appropriate personnel, to perform or have performed upon me, or the above-named patient, appropriate assessment and treatment procedures.

I further authorize My Mental Health, LLC, to release to appropriate agencies, any information acquired in the course of my or the above-named patient's examination and treatment.

Patient/Guarantor Signature ______________________________________ Date _________________

Cancellation / No Show Policy

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 24-hours prior to canceling your appointment to avoid being charged $50.00 which must be paid by the patient before another appointment will be scheduled.

I understand if I fail to show for more than two appointments without notification will result in automatic discharged from care.

My Mental Health, LLC will notify you in writing, via USPS mail, if you are discharged from care.

I have read and understand the above information, and I agree to the terms described:

Patient/Guarantor Signature ____________________________________ Date ________________

Self-Pay

I do not have health insurance and will be responsible for services rendered here at My Mental Health, LLC. I agree to pay My Mental Health, LLC, the full and entire amount of treatment given to me or to the above-named patient at each visit.

Patient/Guarantor Signature __________________________________ Date ________________

INSURANCE WAIVER

Please be advised that all services provided to you in our office will be billed to your insurance company if the provider participates with your plan. You may become the liable third party should your insurance company fail to pay us for the services.

Also, please be aware of what is covered and what is not covered under your specific insurance plan. We will make an attempt to verify coverage from the insurance information you provide, but it is NOT a guarantee of benefits. If insurance has changed, or there is a lapse in coverage; if Coordination of Benefits or PCP referral is required and

not completed; or if for any other reason service is not covered by your insurance company, you will be the liable party.

I hereby acknowledge that I have read, accepted and understood the above insurance waiver for all the services provided to me at My Mental Health,

_________________________ ______________________

Patient / Guarantor Name Date

____

Patient / Guarantor Signature

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ___________________________ Date of Birth: ________________________

Previous Name: ___________________________ Social Security: _______________________

I request and authorize My Mental Health LLC ___________________________ to

☐ Release healthcare information of the patient named above to

☐ Receive Health care information of the patient named above.

Name: ____

Address: ____

City: ______________________________ State: ________ Zip Code: ________________

Phone #: ___________________________ Fax #: __________________________

This request and authorization applies to:

- Healthcare information relating to the following treatment, condition, or dates: ____
- All healthcare information
- Other: ____

Patient Signature: ___________________________________ Date Signed: ___________________________