Psychiatry Associates of **T**upelo
1040-B South Madison St.
Tupelo, MS 38801
Phone (662) 844-4364 Fax (662) 844-4365

OFFICE POLICIES

1. **Payment** – Full fee (or applicable co-payment) is due at the time of service of each appointment at our counseling center. We are glad to file your insurance claims for you. By signing this form you give us permission to provide your insurance company with any information (or copy of your medical records) they request from us in order to process your claim. The patient due account balance should be **PAID BEFORE** a return appointment will be set. If your health, disability or workman's compensation insurance company, attorney, employer or other entity requests other information beyond the regular insurance claim, the preparation of those documents will be billed according to the time required to complete the forms, plus any expenses incurred (photocopying, faxing, etc.). If we have not received payment from your insurance company within 30 days of filing your claim, then the balance will be due entirely by you.
2. A $30 deposit is required before scheduling the initial appointment. This will be applied to your account at the time of your visit. If you miss your appointment or cancel less than 24 hours before your appointment, this $30 will be non-refundable.
3. Telephone consultation and crisis intervention that exceeds 5 minutes or becomes excessive will be prorated at the clinician's hourly rate and charged to the patient's account.
4. **The appointment time is reserved exclusively for you. Therefore, in order for us to effectively treat you and our other clients, please give our office at least a 24 hour notice if your appointment needs to be rescheduled.** Multiple missed appointments prevents us from serving other patients who could have used your time slot and will ultimately lead to us discontinuing your treatment and referring you to another office. An automatic $70.00 Missed Appointment Fee will be charged to your account if you miss or cancel an appointment without a 24 hour notice.
5. Prescription refills are to be obtained at return appointments. Careful monitoring for side effects, drug interactions, drug effectiveness and metabolic blood levels are essential in properly treating the patient. Prescriptions will be called in to your pharmacy only in special situations and a $35 service fee will be charged to your account at Dr. Sheehan and/or Summer Jennings, PMHNP-BC's discretion.
6. Our goal is to serve you as effectively and cordially as possible, respecting the confidential nature of your situation. No information regarding your diagnosis or treatment will be released to anyone without your consent, except as required by law or in a situation when the client's clinician believes violence has been threatened to self or others, when children are believed to have been abused or neglected, and/or when mandated by court subpoena.
7. Please allow up to 1–2 business days for completion of any requests you may have between office visits.
8. Adjustments to the office fee structure may be made annually.
9. There is a $35.00 returned check fee for each check that is returned.

Please ask any questions you have regarding our office policies. Thank you.

I HAVE READ THIS INFORMATION AND UNDERSTAND ITS CONTENT.

_____ _____
PATIENT'S FULL NAME (Please Print) Date of Birth

X _____ _____
SIGNATURE (Patient/Parent/Legal Guardian) Date

Psychiatry Associates of Tupelo
1040B South Madison Street
Tupelo, MS 38801
(662)844-4364 Fax (662)844-4365

PATIENT/CLIENT INFORMATION SHEET

Name:_____ Date:_____

Date of Birth:_____ Age:_____ Sex: M F

1. Please describe your current problem (s):_____

2. Current medications (please include dose, # of times a day, length of time you have been taking):_____

3. Previous medicines used for this illness (please list duration and response):

4. What services do you desire?

___assessment ___medication ___counseling (individual / marital / family / group)
___testing ___other

5. Any other emotional problems in the past (please describe):_____

6. List names and dates of past counselors or psychiatrists:_____

Please Fill Out All Four Pages

7. Hospitalizations (name and dates):_____

_____

Physical illnesses:_____

_____

Surgeries:_____

_____

Allergies:_____

8. Family (list names, ages, and any emotional illnesses)

Parents:_____

_____

_____

Brothers, Sisters:_____

_____

_____

_____

Children:_____

_____

_____

_____

Others (aunts, uncles, grandparents, cousins) who have (or had) emotional or alcohol problems:_____

_____

_____

9. May we send a thank you letter to your referring counselor, pastor or physician? _____ _____

yes no

10. Do you desire a copy of the evaluation to be sent to your counselor or referring physician?

_____yes _____no Name:_____

Address:_____

_____

Signature (parent or custodial parent)_____

PSYCHIATRY ASSOCIATES OF TUPELO

1040 B South Madison St.
Tupelo, MS 38801
(662)844-4364 Fax (662)844-4365

Date:_____

Patient/Client Name:_____

Home Address:_____

City:_____State:_____Zip:_____

Phone Number
Home:_____Cell:_____Work:_____

May patient be contacted at work?_____

Birthdate:_____Age:_____Marital Status:_____

Social Security Number:_____

Patient/Client Occupation:_____

Employer Name:_____

Employer Address:_____

City:_____State:_____Zip:_____

Name of Spouse/Parent, if minor:_____

Spouse/Parent Employer:_____

Name of Nearest Relative:_____

Relationship:_____Phone Number:_____

Name of Responsible Party:_____

Address (if different):_____

City:_____State:_____Zip:_____

I hereby understand that payment is due in full to Sheehan Counseling Center, P. A., at the time of service and if not, I am responsible to make the appropriate financial arrangements prior to the onset of service.

X

Signature of Guarantor/Guardian Date

PATIENT RESPONSIBILITY AGREEMENT
REGARDING USE OF PRESCRIBED MEDICATIONS

I, _____, a patient seen and treated by Clyde Sheehan, MD
(Patient's Name)
and/or Summer Jennings, PMHNP-BC, agree to the following guidelines in regards to use of medications prescribed by Dr. Sheehan and/or Summer Jennings, PMHNP-BC:

1. I will take only the quantity of medication as prescribed by my provider unless approval is obtained from Dr. Sheehan and/or Summer Jennings, PMHNP-BC at my office visit or via phone contact with Dr. Sheehan and/or Summer Jennings, PMHNP-BC to change my/my child's doses. I understand that taking excessive amounts of these medications may cause damage to my body and/or possibly a drug addiction.
2. I will safeguard my supply of medications, thereby not allowing anyone else to use my prescribed medications.
3. I will not trade, sell or give away my medications.
4. When I see other physicians, I will inform them of all the medications prescribed by my provider including the dosages and time of day they are taken to avoid any duplication of prescriptions. I will not seek the same or similar medications from other physicians.
5. I will keep my provider informed of all the medications I am taking from other doctors. Sedatives, alcohol, illicit drugs and street drugs should not be taken with controlled medications.
6. I will inform my provider at each visit to the best of my ability the number of tablets/capsules remaining of each medication and whether or not I have any unfilled prescriptions.
7. I agree not to alter the written prescription given to me by Dr. Sheehan and/or Summer Jennings, PMHNP-BC in any way, understanding that this is considered a felony and punishable by the legal authorities.
8. I understand that a violation of any of these patient responsibilities may be grounds for immediate dismissal of treatment by Dr. Sheehan and/or Summer Jennings, PMHNP-BC.
9. I understand that all controlled medications must be obtained at the same pharmacy, whenever possible.

X **Sign**: _____ Date: _____
(Patient/Parent/Legal Guardian)

Minor Child's Name: _____
(If Applicable)

Psychiatry Associates of Tupelo
1040 B. South Madison St.
Tupelo, MS 38801

Due to *HIPAA* laws, we are unable to disburse information to anyone unless they have been authorized by the patient/patient's parent or guardian. Please list up to 5 people we are allowed to speak with and/or release medical records to about this patient.

***** IF NO NAMES ARE LISTED and/or IF THIS PAGE IS NOT SIGNED OUR OFFICE WILL AUTOMATICALLY ASSUME 'NONE' *****

1. _____
2. _____
3. _____
4. _____
5. _____

X **Sign**: _____ **Date**: _____
(Patient or Parent/Legal Guardian if patient is under 18)

Patient Name: Date:

Are you allergic to any medications? NO ☐ YES ☐ Please list:

Past Medical History

	Yes	No		Yes	No		Yes	No
Diabetes	☐	☐	Osteoporosis	☐	☐	Blood Clots	☐	☐
Chest Pain/Angina	☐	☐	Asthma/COPD	☐	☐	Peripheral Vascular Disease	☐	☐
High Blood Pressure	☐	☐	Stroke/CVA/TIA	☐	☐	Tuberculosis	☐	☐
Heart Disease	☐	☐	Seizures	☐	☐	Depression	☐	☐
Heart Attack	☐	☐	HIV/AIDS	☐	☐	Congestive Heart Failure	☐	☐
High Cholesterol	☐	☐	Hepatitis	☐	☐	Thyroid Disease	☐	☐
Pacemaker	☐	☐	Stomach Ulcer	☐	☐			
Headaches	☐	☐	Liver Disease	☐	☐			
Kidney Stones	☐	☐	Heart Palpitations	☐	☐			
Kidney Disease	☐	☐	Arthritis	☐	☐			
Cancer	☐	☐	Heart Surgery	☐	☐			

Other (please list below)

Current Medications

ROS	(-)	Please check all CURRENT positive findings
Constitutional		Weight loss ☐ Fevers ☐ Chills ☐ Poor appetite ☐ Fatigue ☐ Weight gain ☐ Insomnia ☐ Night sweats ☐
Eyes		Blurry vision ☐ Eye pain ☐ Eye discharge ☐ Eye redness ☐ Decrease in vision ☐ Dry eyes ☐ Double vision ☐
ENT		Sore throat ☐ Hoarseness ☐ Ear pain ☐ Hearing loss ☐ Ear discharge ☐ Nose bleeds ☐ Tinnitus ☐ Sinus problems ☐
Cardiovascular		Chest pain ☐ Palpitations ☐ Rapid heart rate ☐ Heart murmur ☐ Poor circulation ☐ Swelling in the legs or feet ☐
Respiratory		Shortness of breath ☐ Chronic cough ☐ Coughing up blood ☐ History of Tuberculosis ☐ Excess sputum production ☐
Gastrointestinal		Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Blood in the stool ☐ Frequent heartburn ☐ Trouble swallowing ☐
Genitourinary		Increased urinary frequency ☐ Blood in the urine ☐ Incontinence ☐ Painful urination ☐ Urinary retention ☐ Frequent UTIs ☐
Skin		Rash ☐ Hives ☐ Hair loss ☐ Skin sores or ulcers ☐ Itching ☐ Skin thickening ☐ Nail changes ☐ Mole changes ☐
Musculoskeletal		Joint pain ☐ Muscle aches ☐ Frequent leg cramps ☐ Muscle weakness ☐ Bone pain ☐ Joint swelling ☐ Back pain ☐
Psychiatric		Anxiety ☐ Depression ☐ Alcohol or drug dependence ☐ Suicidal thoughts ☐ Panic attacks ☐ Use of anti-depressants ☐
Endocrine		Goiter ☐ Heat intolerance ☐ Cold intolerance ☐ Increased thirst ☐ Change in skin pigment ☐ Excess sweating ☐
Neurological		Seizures ☐ Tremors ☐ Migraines ☐ Numbness ☐ Dizziness/Vertigo ☐ Loss of balance ☐ Slurred speech ☐ Stroke ☐
Hem/Lymphatic		Low blood count ☐ Easy bruising ☐ Swollen lymph nodes ☐ Transfusions ☐ Prolonged bleeding ☐ Blood clots ☐
Allergic/Immun		Allergic reactions ☐ Hay fever ☐ Frequent infections ☐ Hepatitis ☐ HIV positive ☐ Positive tuberculin skin test (PPD) ☐

Social History: Marital Status _____ Occupation (or most recent job held) _____

Non-Smoker (never smoked) ☐ Ex-Smoker ☐ Current Smoker ☐ How many packs per day? _____

Alcohol consumption: Never ☐ Occasional ☐ Frequent ☐

Family History: (Please list any known medical problems)

Father: _____ Mother: _____

Siblings: _____

Your Children: _____

Additional Information: Use this space to provide any additional information which may be important to your health care.

_____ _____

Signature of Reviewing Physician Date Signature of Patient Date

PSYCHIATRY ASSOCIATES OF TUPELO

INSURANCE INFORMATION

Primary Insurance:

Ins Name:_____ Provider Phone #:_____
Policy Holder: Relationship to Patient:_____
Policy ID #: Group #:_____
Policy Holder SS#_____
Policy Holder DOB:___/___/_____ Employer:_____

Secondary Insurance:

Ins Name:_____ Provider Phone #:_____
Policy Holder: Relationship to Patient:_____
Policy ID #: Group #:_____
Policy Holder SS#_____
Policy Holder DOB:___/___/_____ Employer:_____

MEDICARE/MEDICAID INFORMATION:

(MUST Circle Yes or No)

Does the patient have any part Medicare? Yes No

Does the patient have Medicaid? Yes No

I hereby authorize the release of any medical records or other information necessary to process insurance claims. I hereby authorize payment of medical benefits from my insurance carrier to Sheehan Counseling Center, P.A.

X **Sign**: _____ **Date**: _____
(Patient or Parent/Legal Guardian if patient is under 18)

Patient Acknowledgment of Receipt of Privacy Practices Notice

Please Print

I, _____, hereby acknowledge that I have reviewed and received a copy of this office's *Notice of Privacy Practices* explaining:

- How this office will use and disclose my protected health information.
- My privacy rights with regard to my protected health information.
- This office's obligations concerning the use and disclosure of my protected health information.

I understand that the *Notice of Privacy Practices* may be revised from time to time and that I am entitled to receive a copy of any revised *Notice of Privacy Practices* upon request.

I also understand that if I have any questions or complaints, I may contact:

Psychiatry Associates of Tupelo
1040 B South Madison Street
Tupelo, MS 38801

You may also contact the Secretary of the U.S. Department of Health and Human Services with any concerns regarding our privacy and security policies and procedures. Please contact our office for information on how to contact the U.S. Department of Health and Human Services.

Patient or Personal Representative

Signature: _____ Date: ___/___/___

Name: _____
Please Print

Relationship to Patient: _____

For Office Use Only

We made a good-faith effort to obtain an acknowledgment of _____'s receipt of our Notice of Privacy Practices. In spite of these efforts, our office has been unable to obtain a signed acknowledgment of receipt for the following reasons (check all that apply):

☐ Patient refused to sign (date of refusal) ___/___/___.

☐ Communications barriers prohibited obtaining an acknowledgment.

☐ An emergency situation prevented us from obtaining an acknowledgment.

☐ Other _____

Attempt was made by: _____ Date: ___/___/___