# 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)**

***Relationship of Guarantor to Patient:** **Self** ☐ **Spouse** ☐ **Parent** ☐ **Other** _____

***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***

**PRIMARY INSURANCE:**

**Plan Name :** _____ ***Insured's Name:** _____

**Insured's Social Security #:** element_61 ***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.**

***Please read and sign back of form.***

# PATIENT REGISTRATION FORM
# DISCLOSURES & CONSENTS

**Patient Name:** First Name | M.I. | Last Name **Date of Birth:**

## 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 is my 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 MDPAor 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.

## LAB/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:**
(If different from patient)

**GUARANTOR NAME (Please Print):** element_9

# ATTENTION PATIENTS

## *OFFICE POLI CY 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 assistyou.*

## *FOR THERAPY PATIENTS ONLY*

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

***NOTE:***

- ***A $35 fee will be charged for returned check.***
- ***A $29fee 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 checking this box and typing my name below, I am electronically signing my application.

Patient Signature: _____ DATE: _____

Print Name: element_3

**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 out patient alchol / substance abuse treatment**

**No** ☐ **yes** ☐

**if so :**

**Prior out patient tratment was successful ?**

**No** ☐ **yes** ☐

**Number of Prior psychiatric hospitalization ?**

**Date of last Alchohal/substance abuse treatment ?**

element_19

**Involuntary hospitalization in past ?**

**YES** ☐ **NO** ☐

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

**yes** ☐ **No** ☐

## Past Psychiatric History (Please answer):

1) Have you had prior outpatient Psychiatric Treatment? ☐ Yes ☐ No
Comments:

2) Prior outpatient alcohol/substance abuse treatment? ☐ Yes ☐ No
Comments:

3) Prior Outpatient treatment was helpful? ☐ Yes ☐ No

4) Number of Prior Psychiatric Hospitalizations?

5) Date of Last Psychiatric Hospitalization?

6) Date of last alcohol/substance abuse treatment:

7) Prior History of non-suicidal injury ( scratching, cutting, burning)? ☐ Yes ☐ No

8) Prior History of suicide attempt? ☐ Yes ☐ No

Number of attempts:

Last attempt was:

Method of self harm:

Attempt resulting in medical hospitalization: ☐ Yes ☐ No

9) Prior History of Aggression or Violence? ☐ Yes ☐ No

Aggression towards:

Legal charges stemming from aggression: ☐ Yes ☐ No

Childhood History:

1) Were you adopted? ☐ Yes ☐ No

2) Did your biological parents separate or divorce during your childhood? ☐ Yes ☐ No

3) Loss of parent by death prior to age 18? ☐ Yes ☐ No

4) Would you consider your childhood ☐ happy ☐ average ☐ unhappy

5) Socioeconomic status during upbringing: ☐ lower ☐ middle ☐ upper economic class

6) During childhood, were you ever concerned about any form of:

Emotional Abuse ☐ Yes ☐ No

Physical Abuse ☐ Yes ☐ No

Sexual Abuse ☐ Yes ☐ No

Education History:

1) Highest Level of Education?

2) Current Occupation:

Relationship:

1) Current Relationship Status?

2) Have you ever been divorced? ☐ Yes ☐ No

3) Current relationship is ☐ poor ☐ fair ☐ good

4) Are you pregnant? ☐ Yes ☐ No ☐ Not applicable

5) Are you trying to get pregnant? ☐ Yes ☐ No ☐ Not applicable

6) Number of Children?

Legal Issues:

1) Prior difficulties with the legal system ever? ☐ Yes ☐ No

2) Prior Incarceration? ☐ Yes ☐ No

3) Current Legal Issues? ☐ Yes ☐ No

4) Currently on Disability? ☐ Yes ☐ No

5) Currently Seeking Disability: ☐ Yes ☐ No

**Prior History of sucide attempts ?**

**YES** ☐ **No**☐

**IF so :**

**Number of attempts :**.....

**Last Attempt :** .....

**Method of self harm :**.....

**Attempt resulting in hospitalization YES**☐ **NO**☐

**Prior history of aggression or Violance ?**

**yes**☐ **No.**☐

**FAMILY HISTORY**

**Father:** .....

**Age:** .....

**Living :** .....

**Deceased :**.....

**Cause of death:**.....

**If deceased, HIS age at time of his death YOUR age at time of his death**

.....

**Occupation:**.....

**Health:**.....

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

.....

**Mother:** .....

**Age:** element_25

**Living :**.....

**Deceased :**.....

**Cause of death:**.....

**If deceased, HER age at time of his death YOUR age at time of his death**

.....

**Occupation:**.....

**Health:**.....

**Frequency of contact with him: Are you/Have you been close to her?**

.....

**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 persona'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.....

YES ☐ NO ☐ ……you felt so good or hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?

YES ☐ NO ☐ …...You were so irritable that you shouted at people or started fights or arguments?

YES ☐ NO ☐ …….you felt much more self-confident than usual?

YES ☐ NO ☐ ……. you got much less sleep than usual and found you didn't really miss it?

YES ☐ NO ☐ ……...you were much more talkative or spoke much faster than usual?

YES ☐ NO ☐ …… thoughts raced through your head or you couldn't slow your mind down?

YES ☐ NO ☐ ……you were so easily distracted by things around you that you had trouble concentrating or staying on track?

YES ☐ NO ☐ ....……you had more energy than usual?

YES ☐ NO ☐ .....you were much more active or did many more things than usual?

YES ☐ NO ☐. you were much more social or outgoing than usual; for example, you telephoned friends in the middle of the night?

YES ☐ NO ☐. you much more interested in sex than usual?

YES ☐ NO ☐. you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?

YES ☐ NO ☐. spending money got you or family into trouble?

**Have you 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 car into oncoming traffic; inappropriate sexual contact; or poisoning dinner guests? **Yes** ☐ **NO** ☐

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

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

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

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

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

15. Repeating routine actions (in/out of chair, going through doorway, relighting cigarette) a certain number of times until it feels just right? **Yes** ☐ **NO** ☐

16. Needing to touch objects or people? **Yes** ☐ **NO** ☐

17. Unnecessary rereading or rewriting; reopening envelopes before they are mailed? **Yes** ☐ **NO** ☐

18. Examining your body for signs of illness? **Yes** ☐ **NO** ☐

19. Avoiding colors ("red" means blood), numbers ("13" is unlucky) or names (Those that start with "D" signify death) that are associated with dreaded events or Unpleasant thoughts? **Yes** ☐ **NO** ☐

20. Needing to "confess" or repeatedly asking for reassurance that you said or did something correctly? **Yes** ☐ **NO** ☐

# 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<br>None | 1<br>Mild(less than 1 hour) | 2<br>Moderate (1to 3 hours) | 3<br>Severe (3 to 8 hours) | 4<br>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 is it 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:

☐ BRING ALL THE LAB RESULTS AND MR IF ADMITTED AT THE HOSPITAL.

☐ CURRENTLY TAKING RX BOTTLES OR MEDICATIONS AND DOSAGE LIST

☐ IF THE PATIENT IS A MINOR NEEDS TO BE SEEN WITH PARENTS FREELY AVAILABLE TO PROPERLY EVALUATE THE PATIENT.

☐ PLEASE NO LITTLE KIDS.

☐ PLEASE CALL YOUR INSURACE AND ASK FOR YOU CO-PAY BEFORE YOUR VISIT.

# Questionnaire Part A Self Evaluation

Patient's Name: Date: element_2

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; this 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. Concerns with contamination (dirt, germs, chemicals, radiation) or acquiring a Serious illness such as AIDS? **Yes** **NO**
2. Over concern with keeping objects (clothing, groceries, tools) in perfect order or arranged exactly? **Yes** **NO**
3. Images of death or other horrible events? **Yes** **NO**
4. Personally unacceptable religious or sexual thoughts? **Yes** **NO**

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

5. Fire, burglary or flooding of the house? **Yes** **NO**
6. Accidentally hitting a pedestrian with your car or letting it roll down a hill? **Yes** **NO**
7. Spreading an illness (giving someone AIDS)? **Yes** **NO**
8. Losing something valuable? **Yes** **NO**
9. Harm coming to a loved one because you weren't careful enough? **Yes** **NO**