Glen Holley, MS, PA-C

PSYCHMEDCONFIDENTIAL

PATIENT DETAILS

Last Name _____ First Name _____Middle Initial _____

Date of Birth_____ Age____ Gender: M ☐ F ☐ Non-Binary ☐

Marital Status: Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐

Spouse or Parent of Minor (If Applicable): Name _____Relation _____

Address: _____ street _____ city _____

_____ state _____ zip _____

Primary Phone_____ Email _____

Emergency Contact: Name_____Phone_____

INSURANCE INFORMATION

PLEASE NOTE: Our practice does not accept any insurance. We do, however, use this information to process third party resources, labs, and other supplementing services for your treatment.

Insurance Provider _____Group Number _____

Member ID _____ Member Name _____

Relationship to Patient _____Provider Services Number _____

Claims or Mailing Address: _____ street _____ city _____

_____ state _____ zip _____

POLICY REGARDING FIREARMS: I hereby agree that while I am receiving treatment at Psych Med Confidential, any guns that I 1 own will be securely stored away from my home or office and held by a friend, extended family member, or the local police. I also understand that my provider may request proof of compliance with this policy.

☐ By checking this box and typing my name below, I am electronically signing this form.

Printed Name(s) of Parent(s)/Guardian(s): _____

FINANCIAL PROVIDER DETAILS
(IF PATIENT IS NOT PRIMARY FINANCIAL HOLDER)

Last Name _____ of the financial provider _____ First Name _____Middle Initial _____

Address: _____ street _____ city _____

_____ state _____ zip _____

Primary Phone_____ Email _____

Relationship to Patient_____ Driver License Number (ACH Processing)_____

MEDICAL DETAILS

Primary Care Doctor _____

Primary Doctor Address: _____ street _____ city _____

_____ state _____ zip _____

Primary Doctor Phone_____

PLEASE NOTE: Your doctor will refer to this number when calling any prescriptions into your pharmacy. Some medications are unable to be called in due to DEA regulations. Please inform the doctor of any changes to this information.

Pharmacy _____

Pharmacy Address: _____ street _____ city _____

_____ state _____ zip _____

Pharmacy Phone_____

Effective Date:

Authorization for use or disclosure of protected health information (required by the health insurance portability and accountability act, 45 c.F.R. Parts 160 and 164)

1. Authorization. I authorize _____ to use and disclose the protected health information described below to a business entity known as Psych Med Confidential, LLC (individual seeking the information).

2. Effective period. This authorization for release of information covers all past, present, and future periods of health care.

3. Extent of authorization. I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, hiv or aids, and treatment of alcohol or drug abuse).

4. Use. This medical information may be used by the person i authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as i may direct.

5. Termination. This authorization shall be in force and effect until the date _____, at which time this authorization form expires.

6. Revocation rights. I understand that i have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. Benefits. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether i sign this authorization.

8. Disclosure. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

☐ By checking this box and typing my name below, I am electronically signing this form.

Printed Name(s): _____ Date: _____

Patient Name: _____

Chief Complaint: _____

Medications: (please list)

Taking currently: _____

_____

_____

_____

_____

_____

Over the counter medications (OTC): _____

_____

_____

_____

Past medications you used to take: _____

_____

_____

_____

Allergies (Type): _____

_____

Other History:_____

Chief Complaint: _____

Medical History/Concerns:

Any Past Medical History: _____

_____

_____

Past Surgical History: _____

_____

_____

When was your last blood work?_____

_____

_____

Past Psychiatric History: (For Medical Provider do not write in this space) _____

_____

_____

Do you have a Physician for Pain Management? Yes ☐ No ☐

History of Present Illness: (For Medical Provider do not write in this space)_____

_____

_____

1. I hereby authorize Psych Med Confidential to use the telehealth practice platform for telecommunication for evaluating, testing and diagnosing my medical condition.

2. I understand that technical difficulties may occur before or during the telehealth sessions and my appointment cannot be started or ended as intended.

3. I accept that the professionals can contact interactive sessions with video call; however, I am informed that the sessions can be conducted via regular voice communication if the technical requirements such as internet speed cannot be met.

4. I understand that Psych Med Confidential takes pride in offering an extremely high level of service. We also guarantee that if you need an urgent appointment, we will make the time. In order to provide such a high degree of professional service, we have chosen to opt out of participation in health insurance plans. The good news is that you can still be reimbursed for our services. We will provide you insurance-friendly printouts – all you have to do is put them into an envelope – and you will receive direct reimbursement from your health insurance company.

5. I agree that my medical records on telehealth can be kept for further evaluation, analysis and documentation, and in all of these, my information will be kept private.

☐ By checking this box and typing my name below, I am electronically signing this form.

Printed Name(s): _____ Date: _____

Please save this file and email it to GLEN@PSYCHMEDCONFIDENTIAL.COM