

Glen Holley, MS, PA-C
 PSYCHMEDCONFIDENTIAL

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 _____

PATIENT DETAILS

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 _____

INSURANCE INFORMATION

POLICY REGARDING FIREARMS: I hereby agree that while I am receiving treatment at Psych Med Confidential, any guns that I 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): _____

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) _____

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

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 _____

MEDICAL DETAILS

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: _____

Last Name _____ First Name _____ Middle Initial _____

Date of Birth _____ Primary Phone _____ Email _____

1. What is the reason you are seeking psychological assessment at this time?

2. Are you planning on using the results of this assessment to seek accommodations or for some other legal purpose? Please explain how it may be used.

3. Have you received a psychological assessment before? In what year did you have this assessment and what were the conclusions?

4. Were you referred for the assessment? What is the relationship of the person who referred you (treating physician, psychiatrist, therapist, parent, friend, disability office, other)?

5. Please describe if there is a deadline for when you hope to have the assessment completed.



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