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_____

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E ective 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. E ective 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. Bene ts. 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 o ce, other)?

_____

_____

_____

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

_____

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