PSGP Psychiatric Clinicians

25509 Kelly Rd, Ste A. Roseville, MI 48066 Office 586-252-2616

Dear Patients,

Below you will find our intake packet to get scheduled with one of our providers for an evaluation and possible medication. Patients requesting to see one of the MD or DO staff, may have their follow ups done with one of the Physician Assistants for medication management. The MD and DO staff are available for initial evaluations and yearly reviews, The MD, DO, and PA staff do not offer therapy but can assistant in referring to a therapist they work closely with either in our office or locally. All appointments are done in person at our Roseville office, we are not offering telehealth visits. Patients must reside in the State of Michigan to receive services, we do not offer out of state services. If you move out of state the staff will help with a short term of transition while you follow up with a provider in your local state. **The office does not accept Medicaid**.

Intake packets need to be filled out by the person requesting to be a patient, only patients will be contacted for scheduling. We are an adult only office and do not see minors. If you are the legal guardian of an adult and are completing the paperwork for them, a copy of guardianship paperwork will need to be turned in along with the intake packet

Attached is our new patient paperwork. Please fill out all forms, if you feel that one does not apply we ask that you write N/A on it so we are aware it was looked at. Along with a copy of your picture ID and insurance card(s) and complete medication list. **Packets that are returned with incomplete sections or missing pages will not be addressed, please fill out all sections.**

Forms can be filled out with http://www.formswift.com, Adobe fill & sign https://acrobat.adobe.com printed and then scanned/emailed to frontdesk@psgp.info or faxed to 313-563-8443. Cell phone photos of forms are not readable when we print them out and are not acceptable.

Please let us know your insurance information and we can check your coverage. If insurance does not cover anything the first visit is $330.00 and follow ups start at $150.00. The visit fee can be paid by phone at 586-252-2616 or online at http://www.ppaya.com/psgp . Guest payments can be made via the portal without a physical bill..

All of our providers do e-scripts please have your pharmacy information available during the appointment. **The office does not offer hard copy prescriptions**.

Please note that if you have had your intake packet for over 30 days we do ask that you check with the office for any updates or form changes to the packet before returning it.

For any questions, please feel free to email us at frontdesk@pspg.info, or call the office directly at 586-252-2616.

Thank you
PSGP Staff

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NEW PATIENT CHECKLIST

Please initial next to each item that you have read, understand, and agree to the following consent, information and policy forms. Each of these documents are available on 24/7 our website and can also be provided to you by the staff upon request.

_____ FMLA/INSURANCE/NEW PATIENT RESCHEDULING FORM

_____ NO SHOW & CANCELLATION POLICY

_____ CONTROLLED SUBSTANCE POLICY

_____ ACCOUNT BALANCE POLICY

PRINTED NAME: _____

SIGNATURE: _____ DATE: _____

P.S.G.P
Psychiatric Clinicians

25509 Kelly Rd., Ste. A,
Roseville, MI 48066
Phone# 586-252-2616 Fax# 313-563-8443

STAFF USE ONLY
Date/Time_____
Provider_____

PATIENT INFORMATION

EMAIL_____ DATE_____

NAME_____ PHONE#_____

DATE OF BIRTH_____ AGE_____ SEX_____ SOCIAL SECURITY #_____

ADDRESS_____ CITY / ZIP_____

INSURANCE INFORMATION

PRIMARY INSURANCE_____ PHONE #_____

CONTRACT / MEMBER ID_____ GROUP #_____

SECONDARY INSURANCE_____ PHONE #_____

CONTRACT / MEMBER ID_____ GROUP #_____

PRIMARY CARE AND REFERRAL INFORMATION

PRIMARY CARE PHYSICIAN_____ PHONE#_____

ADDRESS_____ CITY / ZIP_____

Were you referred to PSGP? YES (continue below) / NO (skip to REASON(S) FOR VISIT)

Were you referred to a specific provider at PSGP? YES (check all that apply on right) / NO

Are primary care and referral source the same? YES / NO If no, complete info below

□ Dr. James Adamo MD. □ Kaitlin Bettens PA-C
□ Dr. Daniel Smith DO. □ Patrick Cooney PA-C
□ Robert Papazian PsyD. □ Shane Dignan PA-C
□ Melissa Altomare LMSW □ Kevin Bickett PA-C

SOURCE OF REFERRAL_____ PHONE #_____

ADDRESS_____ CITY / ZIP_____

REASON(S) FOR VISIT

What brings you to seek mental health treatment or consultation? Please give some specifics.

_____

_____

_____

Have you ever been seen here or at the old office (131 Kercheval) before? If so by whom and what years?

_____

Do you have any family member's that are seen here? If so whom:

_____

PSYCHIATRIC HISTORY

Have you ever received IN-PATIENT psychiatric treatment? YES / NO

DATES_____-_____ FACILITY_____ REASON_____

Have you ever received OUT PATIENT mental health treatment (counseling or medication management) by a mental health provider, other than your primary care provider? YES / NO

DATES_____-_____ MOST RECENT PROVIDER_____

PHONE#_____ REASON_____

Are you still seeing this provider? YES / NO If no, reason: _____

FAMILY PSYCHIATRIC HISTORY

Has anyone in your family been diagnosed with or experienced:

Bipolar Disorder	YES / NO	Depression	YES / NO	Drug/Alcohol Abuse	YES / NO
Schizophrenia	YES / NO	Anxiety	YES / NO	Suicide	YES / NO
Psychiatric Hospitalization	YES / NO	Anger Issues	YES / NO	ECT	YES / NO

SUBSTANCE ABUSE

Please describe any (past/present) alcohol use: _____

Please describe any (past/present) recreational drug use:_____

Please describe any (past/present) tobacco use: _____

Have you ever received treatment for alcohol/drug use? YES / NO

Have you ever participated in self-help groups? (NA, AA, SAA, etc,) YES / NO

MEDICAL HISTORY

WEIGHT_____ HEIGHT_____

Have you ever had a traumatic brain injury? YES / NO

DATES_____-_____ TREATMENT(S)_____

Have you ever had seizures? YES / NO

DATES_____-_____ TREATMENT(S)_____

Please list ALL medications, OTC (over the counter meds), and herbal supplements. Please include dosage(s). (If none please put N/A)

_____

_____

Please list ALL medical conditions you are being treated for: (If none please put N/A)

_____

_____

Please list any medication/drug allergies: (If none please put N/A)

_____

_____

SOCIAL HISTORY

Employment (circle one): EMPLOYED UNEMPLOYED RETIRED DISABLED HOMEMAKER STUDENT OTHER

If employed, company name: _____ Position: _____ Duration: _____

What is your highest level of education? _____ Trade school or other? _____

Were you ever identified as having a learning disability or require special education classes? YES NO

Sexual Orientation: HETROSEXUAL HOMOSEXUAL BISEXUAL OTHER: _____ PREFER TO NOT DISCLOSE

Status: SINGLE MARRIED DIVORCED PARTNERED WIDOWED (date_____) DATING PREFER TO NOT DISCLOSE

Do you have any children? YES / NO

Please list ages and genders: _____

Living situation – (please list everyone that lives with you, by relationship):

_____

_____

Have you ever served in the military? YES / NO Branch: _____ Dates served: _____

Have you ever had any legal issues? YES / NO Explain: _____

EMERGENCY CONTACT INFORMATION

NAME:_____ RELATIONSHIP:_____ PHONE#_____

SIGNATURE

The information above is accurate and complete to the best of my knowledge. My signature below certifies that I am the person who has completed this form (if legal guardian, guardianship paperwork must be turned in with intake packet)

PATIENT SIGNATURE: _____ DATE: _____

PSGP Psychiatric Clinicians

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Adult ADHD Self Report Scale (ASRS-V1.1) Symptom Checklist

Patient Name _____ Date _____

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment.	NEVER	RARELY	SOMETIMES	OFTEN	VERY OFTEN
PART A					
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?					
3. How often do you have problems remembering appointments or obligations?					
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
6. How often do you feel overly active and compelled to do things, like you were driven by a motor					
PART B					
7. How often do you make careless mistakes when you have to work on a boring or difficult project?					
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?					
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?					
10. How often do you misplace or have difficulty finding things at home or at work?					
11. How often are you distracted by activity or noise around you?					
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?					
13. How often do you feel restless or fidgety?					
14. How often do you have difficulty unwinding and relaxing when you have time to yourself ?					
15. How often do you find yourself talking too much when you are in social situations?					
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?					
17. How often do you have difficulty waiting your turn in situations when turn taking is required?					
18. How often do you interrupt others when they are busy?					

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Mood Disorder Questionnaire (MDQ)

Patient Name _____ Date _____

INSTRUCTIONS: Please answer each question 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 so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	☐	☐
… you were so irritable that you shouted at people or started fights or arguments?	☐	☐
… you felt much more self-confident than usual?	☐	☐
… you got much less sleep than usual and found that you didn't really miss it?	☐	☐
… you were more talkative or spoke much faster than usual?	☐	☐
… thoughts raced through your head or you couldn't slow your mind down?	☐	☐
… you were so easily distracted by things around you that you had trouble concentrating or staying on track?	☐	☐
… you had much more energy than usual?	☐	☐
… you were much more active or did many more things than usual?	☐	☐
… you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	☐	☐
… you were much more interested in sex than usual?	☐	☐
… you did things that were unusual for you or that other people might have thought were excessive, foolish or risky?	☐	☐
… spending money got you or your family in trouble?	☐	☐

2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?

3. How much of a problem did any of these cause you - like being able to work; having family, money or legal troubles; getting into arguments or fights?

☐ No problem ☐ Minor problem ☐ Moderate problem ☐ Serious problem

4. Have any of your blood relatives (children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?

5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?

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Patient Health Questionnaire and General Anxiety Disorder

(PHQ-9 and GAD-7)

Patient Name _____ Date _____

Over the last 2 weeks, How often have you been bothered by any of the following problems?
Please circle your answers.

PHQ-9	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very difficult** **Extremely difficult**

Over the last 2 weeks, How often have you been bothered by any of the following problems?
Please circle your answers.

GAD-7	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid, as if something awful might happen	0	1	2	3
Add the score for each column	0	1	2	3

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very difficult** **Extremely Difficult**

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Rapid Mood Screener (RMS)

Patient Name _____ Date _____

Are you among the millions of people who have depressive symptoms? Answer the following questionnaire about your medical history and provide it to your doctor or nurse to assist in an important conversation about your mood.

Please select one response for each question. You can complete the **RMS** in less than 2 minutes.

	YES	NO
1. Have there been at least 6 different periods of time (at least 2 weeks) when you felt deeply depressed?	☐	☐
2. Did you have problems with depression before the age of 18?	☐	☐
3. Have you ever had to stop or change your antidepressant because it made you highly irritable or hyper?	☐	☐
4. Have you ever had a period of at least 1 week during which you were more talkative than normal with thoughts racing in your head?	☐	☐
5. Have you ever had a period of at least 1 week during which you felt any of the following: unusually happy; unusually outgoing; or unusually energetic?	☐	☐
6. Have you ever had a period of at least 1 week during which you needed much less sleep than usual?	☐	☐

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Wender Utah Rating Scale

Instructions: As a child I was or had:

	Not at all or very slightly	Mildly	Moderately	Quite a bit	Very Much
1. concentration problems, easily distracted	0	1	2	3	4
2. anxious, worrying	0	1	2	3	4
3. nervous, fidgety	0	1	2	3	4
4. inattentive, daydreaming	0	1	2	3	4
5. hot or short tempered, low boiling point	0	1	2	3	4
6. temper outbursts, tantrums	0	1	2	3	4
7. trouble with stick-to-it-tiveness, not following through, failing to finish things started	0	1	2	3	4
8. stubborn, strong willed	0	1	2	3	4
9. sad or blue, depressed, unhappy	0	1	2	3	4
10. disobedient with parents, rebellious, sassy	0	1	2	3	4
11. low opinion of myself	0	1	2	3	4
12. irritable	0	1	2	3	4
13. moody, ups and downs	0	1	2	3	4
14. angry	0	1	2	3	4
15. acting without thinking, impulsive	0	1	2	3	4
16. tendency to be immature	0	1	2	3	4
17. guilty feelings, regretful	0	1	2	3	4
18. losing control of myself	0	1	2	3	4
19. tendency to be or act irrational	0	1	2	3	4
20. unpopular with other children, didn't keep friends for long, don't get along with other children	0	1	2	3	4
21. trouble seeing things from someone else's point of view	0	1	2	3	4
22. trouble with authorities, trouble with school, visits to principal's office	0	1	2	3	4
23. as a child in school I was (or had): overall a poor student, slow learner	0	1	2	3	4
24. trouble with mathematics or numbers	0	1	2	3	4
25. not achieving up to potential	0	1	2	3	4

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Sheehan Disability Scale

A brief, patient rated, measure of disability and impairment.

Please mark ONE circle for each scale.

WORK* / SCHOOL

The symptoms have disrupted your work / school work:

Not at all	mildly			moderately			markedly			extremely
0	1	2	3	4	5	6	7	8	9	10

☐ I have not worked / studied at all during the past week for reasons unrelated to the disorder.
*Work includes paid, unpaid volunteer work or training.

Social Life

The symptoms have disrupted your social life / leisure activities:

Not at all	mildly			moderately			markedly			extremely
0	1	2	3	4	5	6	7	8	9	10

Family Life / Home Responsibilities

The symptoms have disrupted your family life / home responsibilities:

Not at all	mildly			moderately			markedly			extremely
0	1	2	3	4	5	6	7	8	9	10

Days Lost

On how many days in the last week did your symptoms cause you to miss school or work or leave you unable to carry out your normal daily responsibilities? _____

Days Underproductive

On how many days in the last week did you feel so impaired by your symptoms, the even though you went to school or work, your productivity was reduced? _____

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CONSENT FOR TREATMENT

By signing this form, I am requesting and giving my consent to PSGP Psychiatric Clinicians formally Psychiatric Services of Grosse Pointe, and the doctors, nurses, psychologists and other people who work here, to provide me with outpatient medical and mental health treatment, do tests, and give other care.

I understand that such treatment my be disruptive to a patient and may cause a patient to become anxious or develop anxieties, depression or other symptoms.

I understand that certain medications may be prescribed in connection with such treatment and that such medications may have various side effects, known and unknown. Such medications are approved by the Food and Drug Administration.

I understand that no guarantee or promise, oral or written has been given by anyone either as to the result of treatment that may be obtained, or as to the risk, consequences or complications that may be involved in the treatment.

I know if I have questions about my medical and/or mental health care or tests, I should be sure to ask the doctors or nurses about them. I know it is up to me to tell the doctors or nurses about drugs or medicines I am taking.

I understand that communications between PSGP Psychiatric Clinicians, and family members involved in my care may be determined to be appropriate to my care and, therefore, authorize such communication. I also understand that communications between my primary care or referring physician may be necessary to my treatment and authorize such communication. I will disclose information regarding my physical health, and I understand that a health report will be requested from my physician at the initiation of treatment.

I give permission to PSGP Psychiatric Clinicians, to provide my medical and/or mental health records (or copies of them) to hospitals, clinics, doctors, nurses, and health care providers who validly request them for the purpose of my medical and/or mental health care. This permission includes medical and/or mental health records which relate to diagnosis or treatment of substance abuse, psychological conditions, or sexually transmitted diseases.

FEES AGREEMENT

I understand that it is my responsibility to obtain information about my insurance coverage from my employer or insurance carrier and that PSGP Psychiatric Clinicians, staff is available to guide me in securing information.

I understand that PSGP Psychiatric Clinicians, will bill me its charges for services and facilities provided to me. I agree to pay PSGP Psychiatric Clinicians all charges for services rendered to me promptly after I am billed. I understand that PSGP Psychiatric Clinicians is not responsible if for some reason PSGP Psychiatric Clinicians is not paid by an insurer, government payer, or third party-payer and that, except as stated below, payment for services rendered by PSGP Psychiatric Clinicians is my responsibility. I agree that I will pay PSGP Psychiatric Clinicians the amount of any charges not paid by insurance or another third-party payer, unless and only to the extent that my health insurer has an agreement with PSGP Psychiatric Clinicians, which prohibits billing me for PSGP Psychiatric Clinicians services and fees.

If I file a claim for hospital, surgical, physician, disability, no-fault liability or hospital benefit insurance related to the services rendered by PSGP Psychiatric Clinicians, I hereby assign to PSGP Psychiatric Clinicians any money that I am entitles to directly to PSGP Psychiatric Clinicians. I also PSGP Psychiatric Clinicians agree that I will sign any necessary authorizations or consents which PSGP Psychiatric Clinicians requests as necessary to enable my insurance companies to pay any such money directly to PSGP Psychiatric Clinicians. If any similar agreement is made with any other person after today, I agree to pay PSGP Psychiatric Clinicians, the money needed to pay my bill before any other such person or organization is paid.

I UNDERSTAND THAT I MAY BE CHARGED FOR MISSED APPOINTMENTS WHICH HAVE NOT BEEN CANCELLED WITHIN 24 HOURS OF THE SCHEDULED APPOINTMENT TIME.

I HEREBY CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT TO TREATMENT AND FEES AGREEMENT AND THAT THE EXPLANTIONS REFFERED TO HAVE BEEN MADE.

WITNESS_____ PATIENT SIGNATURE _____

DATE_____ DATE_____

PARENT/LEGAL GUARDIAN_____ DATE_____

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ONE TIME AUTHORIZATION AGREEMENT
(MEDICARE INSURANCE PATIENTS ONLY)

I (print name)_____, request that payment of the authorized Medicare or other insurance benefits be made on my behalf for any services furnished by PSGP Psychiatric Clinicians. I authorize any holder of medical psychiatric information about me to be released to the Health Care Financing Administration and its agents for any information needed to determine these benefits for related services. I understand my signature requests payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance indicated in item 9 of the HCFA 1500 form or elsewhere on other approval claim forms, my signature authorized releasing the information to the insurer or agency shown. Payment is to go to the provider for services rendered.

Patient Signature: _____ Date: _____

Consent of Legal Guardian or Personal Representative is necessary if patient is unable to sign or is a minor. Proof of such will be required.

Guardian/Parent/Personal Representative Signature: _____

Relationship to Patient: _____ Date: _____

(Office Staff Only)
Witness Signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE
(HIPAA POLICY- Health Insurance Portability & Accountability Act)

A Notice of Policies and Practices to protect the privacy of your patients health information has been given to me and I understand the provisions. I understand that the terms of the Notice may change and that I may obtain a revised copy by contacting the Privacy Office listed in the notice.

I am signing that I understand and have received the HIPPA policy form:

Patient Signature: _____Date: _____

Consent of Legal Guardian or Personal Representative is necessary if patient is unable to sign or is a minor. Proof of such will be required.

Guardian/Parent/Personal Representative Signature: _____

Relationship to Patient: _____ Date: _____

(Office Staff Only)
Witness Signature: _____ Date: _____

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CONSENT TO RELEASE INFORMATION
(TO INSURANCE COMPANY)

Your records which are held in custody by PSGP Psychiatric Clinicians, are privileged and confidential. A general medical authorization to release psychiatric and/or psychological information is invalid according to Federal Regulation, 42, CFR, Part 2. Your records will not be released without this waive, or one that complies with office policy, except under the following circumstances: In the event of a valid court order or an emergency.

Patient Name: (Print) _____

Birth Date: _____ Social Security Number: _____

I authorize PSGP Psychiatric Clinicians to release to my **INSURANCE COMPANY**

NAME OF INSURANCE COMPANY:_____
(PLEASE WRITE "N/A" IF YOU DO NOT HAVE INSURANCE)

The following information will be released if necessary:
DIAGNOSIS, PROGNOSIS, PROGRESS NOTES, DATES OF SERVICE
to include any substance abuse information and psychiatric records

Purpose or need for this information: PAYMENT ON CLAIMS, VERIFY BENEFITS

This consent will expire upon satisfaction of the need for disclosure, unless otherwise specified. I may revoke this authorization at any time provided I notify PSGP Psychiatric Clinicians in writing to that effect. However, such revocation will have no effect on any action previously taken. I understand that once the specified information herein has been disclosed to the recipient, that entity and or previously taken. I understand that one the specified information herein has been disclosed to the recipient, that entity and or recipient may re-disclose the information received and said information may no longer be protected by the Federal Privacy Laws.

Will expire upon satisfaction of the need for disclosure, not to exceed 90 days after termination of treatment.

Patients Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

(Office Staff Only) Witness Signature: _____ Date: _____

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CONSENT TO RELEASE INFORMATION
(TO PRIMARY CARE PHYSICIAN)

Your records which are held in custody by PSGP Psychiatric Clinicians, are privileged and confidential. A general medical authorization to release psychiatric and/or psychological information is invalid according to Federal Regulation, 42, CFR, Part 2. Your records will not be released without this waive, or one that complies with office policy, except under the following circumstances: In the event of a valid court order or an emergency.

Patient Name: (Print) _____

Birth Date: _____ Social Security Number: _____

I authorize PSGP Psychiatric Clinicians to release to my **PRIMARY CARE PHYSICIAN**

NAME OF PRIMARY CARE PHYSICIAN/ADDRESS:_____

(PLEASE WRITE "N/A" IF YOU DO NOT HAVE A PCP PHYSICIAN OR YOU WISH NOT TO RELEASE INFORMATION TO ONE AT THIS TIME**)**

The following information will be released if necessary:
LETTER TO PRIMARY CARE PHYSICIAN TO INCLUDE; DIAGNOSIS, PROGNOSIS, PROGRESS NOTES, DATES OF SERVICE, MEDICATIONS, AND RECOMMENDED TREATMENT.
to include any substance abuse information and psychiatric records

Purpose or need for this information TO NOTIFY PRIMARY CARE PHYSICIAN OF PATIENT STATUS

This consent will expire upon satisfaction of the need for disclosure, unless otherwise specified. I may revoke this authorization at any time provided I notify PSGP Psychiatric Clinicians in writing to that effect. However, such revocation will have no effect on any action previously taken. I understand that once the specified information herein has been disclosed to the recipient, that entity and or previously taken. I understand that one the specified information herein has been disclosed to the recipient, that entity and or recipient may re-disclose the information received and said information may no longer be protected by the Federal Privacy Laws.

Will expire upon satisfaction of the need for disclosure, not to exceed 90 days after termination of treatment.

Patients Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

(Office Staff Only) Witness Signature: _____ Date: _____

PSGP Psychiatric Clinicians

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CONSENT TO RELEASE OR RECEIVE INFORMATION

Your records which are held in custody by PSGP Psychiatric Clinicians, PLLC., are privileged and confidential. A general medical authorization to release psychiatric and/or psychological information is invalid according to Federal Regulation, 42, CFR, Part 2. Your records will not be released without this waiver, or one that complies with office policy, except under the following circumstances: In the event of a valid court order or an emergency.

Patient Name: _____

Birthdate: _____ **Social Security Number:** _____

I authorize PSGP Psychiatric Clinicians, PLLC.: (circle one preference only)

Release to: _____

_____

Receive from: _____

_____

The following information:

Psychiatric/Psychological Evaluation*

Progress Notes* _____All dates of service; or From _____ To _____

Entire Chart (to include all progress notes, medication calls, consents for meds, medication log)*

Other*_____

To include any substance abuse information and psychiatric records

Purpose or need for the information: _____

This consent will expire upon satisfaction of the need for disclosure, unless otherwise specified. I may revoke this authorization at any time provided I notify PSGP Psychiatric Clinicians, PLLC., in writing to that effect. However, such revocation will have no effect on any action previously taken. I understand that once the specified information herein has been disclosed to the recipient, that entity and or recipient may re-disclose the information received and said information may no longer be protected by the Federal Privacy Laws. We will not condition treatment, payment, enrollment or eligibility for benefits on whether this authorization is signed or not. A copy of this signed authorization may be obtained upon request.

Upon satisfaction of the need for disclosure. This authorization will expire one year from date signed.

Patient's Signature: _____Date: _____

Consent of Legal Guardian or Personal Representative is necessary if Client is unable to sign. Proof of such will be required.

Signature of Guardian, Parent, or Personal Representative: _____

Relationship to Patient: _____Date: _____

Witness Signature: _____Date: _____

PSGP Psychiatric Clinicians

25509 Kelly Rd, Ste A. Roseville, MI 48066 Office 586-252-2616

Please remember to include in the returned paperwork, Copies of the front and back of your picture ID that include address (driver license or state ID) passports will not be accepted, and the front and back of ALL INSURANCE cards.