NEW PATIENT INSURANCE VERIFICATION AND AUTHORIZATION

George M. Northrup, M.D.

Date: _____ Referred By: _____

Patient Name: _____ Cell Phone: _____

Home Phone: _____ Email: _____

Home Address: _____

(City,State,Zip) _____

Employer Name: _____ Work Phone: _____

Employer Address: _____

Date of Birth: _____ Social Security #: _____

Insurance Company: _____

Benefits Telephone: _____

Name of Insured: _____ Insured Employer: _____

Insured Date of Birth: _____ Insured SS#: _____

Relationship to Patient: _____

Member Identification #: _____ Employer Group#: _____

Authorization Required? ☐ Yes ☐ No

Have you already obtained an authorization?? ☐ Yes ☐ No Auth# _____

DO NOT COMPLETE BELOW THIS LINE. FOR OFFICE USE ONLY.

EDOC: _____ Deductible: _____ Met to Date: _____

% of Coverage: _____ Yearly Max: _____

Co-pay 1st visit: _____ Co-pay follow-ups: _____

Claims Mailing Address: _____

_____

_____

Authorization Number: (90792 x ___) _____ (99213-14 x___) _____

Staff Signature: _____ Date: _____

GEORGE M. NORTHRUP, M.D.
GENERAL PSYCHIATRY – FORENSIC PSYCHIATRY

3601 WEST AZEELE STREET
TAMPA, FLORIDA 33609

OFFICE (813) 350-9500
FACSIMILE (813) 350-9544

Notice of Privacy Practices
Patient Acknowledgement

Patient Name: _____

Date of Birth: _____

I have received and understand this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and make changes regarding all protected health information resident at, or controlled by this practice. If changes to the policy occur, this practice will provide me a revised Notice of Privacy Practices upon request.

Signature: _____

Date: _____

Relationship to patient (if signed by a personal representative of patient):

_____

New Patient Questionnaire

Name_____ Date_____

DOB_____ Age_____ Height_____Weight_____Sex_____

Sexual Orientation: (check) ☐ Heterosexual ☐ Homosexual / Lesbian ☐ Bisexual ☐ Transexual

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

Living Situation (eg..own/rent, who is in household)_____

Allergies _____

General – (check all that are problems for you)

1 ☐ not getting along with other people
2 ☐ not fitting in with peers
3 ☐ being shy
4 ☐ being uncomfortable when talking to people
5 ☐ feeling uncomfortable in social settings
6 ☐ acting rude or overbearing
7 ☐ being suspicious of others
8 ☐ not having close friends
9 ☐ feeling lonely
10 ☐ feeling like people are against me

11 ☐ feeling anxious or uptight
12 ☐ being afraid of things
13 ☐ not being able to stop worrying
14 ☐ not being able to relax
15 ☐ feeling restless/tense
16 ☐ having been traumatized
17 ☐ having nightmares
18 ☐ having flashbacks
19 ☐ avoiding people, places or things

20 ☐ being overweight
21 ☐ having physical handicap
22 ☐ having unattractive face
23 ☐ being noticed for physical appearance

24 ☐ other problem with appearance: _____

25 ☐ being afraid of failing on the job
26 ☐ boss being critical or unfair
27 ☐ working too many hours
28 ☐ job creating health problems
29 ☐ job having no future
30 ☐ being bored on the job

31 ☐ children misbehaving
32 ☐ disagreeing on how to raise children
33 ☐ child or partner having medical problem
34 ☐ child or partner having emotional problem
35 ☐ partner having problem with drugs or alcohol
36 ☐ partner being unfaithful
37 ☐ having sexual problems in relationship
38 ☐ being unfaithful to partner
39 ☐ spouse working too many hours
40 ☐ arguing with partner over money

41 ☐ other regarding spouse, children or in-laws: _____

42 ☐ budgeting money
43 ☐ not making enough money
44 ☐ not having a steady income
45 ☐ having to spend savings
46 ☐ having unpaid bills
47 ☐ wasting money
48 ☐ spouse being careless with money
49 ☐ worry about diseases or illness

50 ☐ having problems with sexual relationship

51 ☐ disliking sex

52 ☐ being troubled by sexual attitudes of others

53 ☐ being troubled by unusual sexual behavior

Do you have any odd or unusual habits? (explain)

Do you have any habits that bother other people? (explain)

Is there a history for any of the following in :

	Yourself	A blood relative
☐	Depression	Depression
☐	Anxiety	Anxiety
☐	Substance Abuse	Substance Abuse
☐	Psych. Hospitalization	Psych. Hospitalizaition
☐	Legal Problems	Legal Problems
☐	Suicide Attempt	Suicide attempt

If Hospitalizations (Yourself) or legal problems explain:

I was raised by_____. I have_____siblings. (___Brothers. ___Sisters)

Describe your maternal (i.e. mother) figure in 3 words _____

Describe your paternal (i.e. father) figure in 3 words_____

Describe your childhood in 3 words_____

MEDICAL

Current Medication	Dosage	Reason for medication

Hospitalizations/Surgeries

Year	Where	Nature of Illness

Medical Cont'd

Is there a history of the following in :

Yourself	A Blood Relative
☐ High blood pressure	☐ High Blood Pressure
☐ Diabetes	☐ Diabetes
☐ Stroke	☐ Stroke
☐ Heart Attack	☐ Heart Attack
☐ Cancer	☐ Cancer
Type_____	Type_____
☐ Thyroid Problem	☐ Thyroid Problem
☐ Liver Problem	☐ Liver Problem
☐ Kidney Problem	☐ Kidney Problem
☐ Alzheimers	☐ Alzheimers

Social

Education: Highest Grade Completed 1-12 _____

Additional Education: ☐

Military History: ☐ Y ☐ N : if Y please give details below

_____

Occupation_____

Employer_____

Substance use habits

Circle all that apply:

☐ Tobacco ○ Past ○ Current Avg. # of packs/day_____ for # of years_____

☐ Alcohol ○ Past ○ Current Avg. # of drinks/week_____for # of years_____ # of DUI charges_____

☐ Cocaine ○ Past ○ Current Avg. use/week _____ for # of years_____

☐ Marijuana ○ Past ○ Current Avg. use/week _____ for # of years _____

☐ Speed/Amph. ○ Past ○ Current Avg. use/week _____ for # of years _____

☐ Hallucinogens ○ Past ○ Current # of trips lifetime _____

☐ Other ○ Past ○ Current Substance_____ Details of Use_____

Physical Symptom Inventory

Have you ever had any of the following?	Yes	No
Significant Weight gain? (____ lbs.)	☐	☐
Significant Weight loss? (____ lbs.)	☐	☐
Weakness in arms or legs?	☐	☐
Headaches which are chronic or severe?	☐	☐
Difficulty walking?	☐	☐
Loss of consciousness?	☐	☐
Problems with vision other than needing glasses?	☐	☐
Change in hearing?	☐	☐
Dizziness?	☐	☐

	Yes	No
Daily Cough?	☐	☐
Shortness of breath?	☐	☐
Discomfort in chest?	☐	☐

	Yes	No
Frequent swelling in ankles?	☐	☐
Pain in legs while standing?	☐	☐
High blood pressure?	☐	☐

	Yes	No
Severe abdominal pain?	☐	☐
Frequent heartburn or indigestion?	☐	☐
Tar-colored or bloody bowel movements?	☐	☐
Do you lose control of stool at times?	☐	☐

	Yes	No
Bloody or unusual appearing urine?	☐	☐
Do you lose control of urine at times?	☐	☐
Frequent awakening at night?	☐	☐
Any skin problems?	☐	☐
Neck pain or stiffness?	☐	☐
Back pain or injury?	☐	☐
Sexual problems?	☐	☐

IS THERE ANYTHING YOU WOULD LIKE TO ADD WHICH YOU HAVE NOT ALREADY?

APPOINTMENT CONFIRMATION OR OTHER TELEPHONE CALLS FROM THIS OFFICE MAY BE MADE TO:

NUMBER(s): _____. OKAY TO LEAVE MESSAGE? ☐ **Y** ☐ **N**

IN CASE OF EMERGENCY YOU HAVE MY PERSMISSION TO CONTACT:

NAME & RELATIONSHIP TO PATIENT: _____ PHONE: _____

SIGNATURE OF PATIENT: _____ **DATE:** _____

IF YOU ARE HERE FOR A SOCIAL SECURITY, SHORT TERM DISABILITY, LONG TERM DISABILITY OR FMLA EVALUATION PLEASE COMPLETE THE FOLLOWING:

REASON FOR LEAVE/SYMPTOMS?

REFERRING PRIMARY CARE PHYSICIAN NAME: _____ PHONE: _____

DATE OF ONSET OF SYMPTOMS: _____ DATE OF LAST DAY WORKED: _____

NURSE CASE MANAGER NAME: _____ PHONE: _____

HAS THIS REQUEST BEEN DENIED BY ANOTHER OTHER PHYSICIAN WITHIN THE PAST 30 DAYS? ☐ **Y** ☐ **N**

IF YOU ANSWERED, YES PLEASE STATE REASON FOR DENIAL: _____

PATIENT ACKNOWLEDGEMENT OF FORMS POLICIES. PLEASE READ AND INITIAL BELOW.

I AM AWARE I WILL BE CHARGED FOR COMPLETION OF ANY FORMS. I UNDERSTAND THAT FORMS WILL ONLY BE SUBMITTED UPON PAYMENT OF THESE FEES. COMPLETION OF FORMS DOES NOT GUARANTEE APPROVAL OF YOUR CLAIM/REQUEST. FINAL CONSIDERATIONS ARE MADE BY YOUR EMPLOYER/ CARRIER.

I UNDERSTAND THE ABOVE INFORMATION PERTAINING TO FORM COMPLETION. **INITIAL:** _____

George M. Northrup, M.D., P.A.

PATIENT ACKNOWLEDGEMENT

_____ Remembering the date and time of my scheduled appointment is **MY** responsibility. Reminder calls are a courtesy and do not negate my responsibility for my sessions. I agree to provide the office a minimum of 24 business hours notice if I need to cancel/ reschedule my appointment.

This office does it best to stay on schedule. As such, we do not overbook appointments. Scheduling an appointment fills a slot on Dr. Northrup's schedule. Missing appointments or arriving late not only disrupts the flow of the schedule, but also is not fair to other scheduled patients or to those who may need to be seen on an urgent basis.

_____ I understand I will be billed $85.00 for any appointment I fail to keep or cancel without 24 *business* hours notice.

_____ I may reduce my no show/ cancellation fee to $50 by leaving a working credit card which will be run on file. I give my permission to keep the following credit card information on file:

VISA/MC/DISCOVER_____, EXP. _____/_____,

CVV _____ and I understand my card will be billed in the event of the aforementioned. I understand I will receive written notification from the office if my card is charged.

_____ My portion of payment for services is due at the time services are rendered.

_____ I understand if my account is turned over to a collection agency for non-payment, I will be responsible for the collection agency fee as well.

_____Requests for letters and forms to include disability forms will constitute an additional charge based on the necessary time required for their completion. At least five (5) business days should be allotted for their completion.

_____ There will be a $20 charge for Prior or Continuing Authorizations for medications.

George M. Northrup, M.D., P.A.

PATIENT ACKNOWLEDGEMENT(cont.)

_____ This physician's office has a relationship with ME, not my insurance company. Some insurance companies will deny various payments. The office will bill my insurance promptly. Whatever my insurance company does not pay, after 60 days, I will be billed for that total outstanding balance. I understand I have the right to question my insurance company's denial of fees or policies regarding mental health benefits. I further understand the physician's officer personnel will do their best to assist me in understanding and utilizing my benefits.

_____ I authorize use of my information, including my diagnosis, to all my Insurance Companies. I authorize this doctor's office to act as my agent in helping me obtain payment for my Insurance Companies. I authorize payment direct to this doctor's office. *If you prefer your information not be disclosed. Please ask to speak to a member of the staff.

_____Although in some cases my prescription request will be handled on the same day, I will give this office a minimum of three (3) business day notice when requesting a medication refill or new prescription.

_____Prescription refills will **NOT** be completed during evenings, weekends, or holiday hours.

My signature below and initial above indicate that I have read and understand and I agree to comply with this two (2) page agreement.

_____ _____

Signature of Responsible Party Date

DEPRESSION ASSESSMENT SCALE

Please check the answer to each question below which best applies to you:

For the past two weeks I have been…

1. feeling unhappy or sad.

☐ DO NOT AGREE ☐ SLIGHTLY AGREE ☐ MODERATELY AGREE ☐ STRONGLY AGREE

2. angry or irritable more often than my old self.

☐ DO NOT AGREE ☐ SLIGHTLY AGREE ☐ MODERATELY AGREE ☐ STRONGLY AGREE

3. having little interest in fun activities.

☐ DO NOT AGREE ☐ SLIGHTLY AGREE ☐ MODERATELY AGREE ☐ STRONGLY AGREE

4. not sleeping like I normally do (whether sleeping too much or too little).

☐ DO NOT AGREE ☐ SLIGHTLY AGREE ☐ MODERATELY AGREE ☐ STRONGLY AGREE

5. not eating like I normally do (whether eating too much or too little).

☐ DO NOT AGREE ☐ SLIGHTLY AGREE ☐ MODERATELY AGREE ☐ STRONGLY AGREE

6. wishing I were dead, or thinking of suicide.

☐ DO NOT AGREE ☐ SLIGHTLY AGREE ☐ MODERATELY AGREE ☐ STRONGLY AGREE

7. unable to concentrate or pay attention very well.

☐ DO NOT AGREE ☐ SLIGHTLY AGREE ☐ MODERATELY AGREE ☐ STRONGLY AGREE

8. more forgetful than my old self.

☐ DO NOT AGREE ☐ SLIGHTLY AGREE ☐ MODERATELY AGREE ☐ STRONGLY AGREE

9. lacking motivation and energy.

☐ DO NOT AGREE ☐ SLIGHTLY AGREE ☐ MODERATELY AGREE ☐ STRONGLY AGREE

10. feeling down on myself and/or my future.

☐ DO NOT AGREE ☐ SLIGHTLY AGREE ☐ MODERATELY AGREE ☐ STRONGLY AGREE

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We care about our patients' privacy and strive to protect the confidentiality of your medical information at this practice. New federal legislation requires that we issue this office Notice of our privacy practices. You have the right to the confidentiality of your medical information, and this practice is required by law to maintain the privacy of that protected health information. This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have any questions about this Notice, please contact the Privacy Officer at this practice.

Privacy Officer: Brittannie Woll, Clinic Administrator Effective: March 1, 2012

Who Will Follow This Notice

Any health care professional authorized to enter information into your medical record, all employees, staff and other personnel at the practice who may need access to your information must abide by this Notice. All subsidiaries, business associates, sites and locations of this practice may share medical information with each other for treatment purposes or health care operations described in this Notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be shared.

How We May Use and Disclose Medical Information About You

The following categories describe different ways that we may use and disclose medical information without your specific consent or authorization. Examples are provided for each category of uses or disclosures. Not ever possible use or disclosure in a category is listed.

For Treatment. We may use medical information about you to provide you with medical treatment services. Example: In treating you for a specific condition, we may need to know if you have allergies that could influence which medication we prescribe for the treatment process.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive from us may be billed and payment may be collected from you, an insurance company or a third party. Example: We may need to send your protected health information, such as your name, address, office visit date, and codes identifying your diagnosis and treatment to your insurance company for payment.

For Health Care Operations. We may use and disclose medical information about you for health care operations to assure that you receive quality care. Example: We may use medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

Other Uses or Disclosure That Can Be Made Without Your Consent or Authorization

- As required during an investigation by law enforcement agencies
- To avert a serious threat to public health or safety
- As required by military command authorities for their medical records
- To workers' compensation or similar programs for processing of claims
- In response to a legal proceeding
- To a coroner or medical examiner for identification of a body
- If an inmate, to the correctional institution or law enforcement official
- As required by the US Food and Drug Administration (FDA)

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Uses and Disclosures of Protected Health Information Requiring Written Authorization

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you give us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will thereafter no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain records of the care we have provided you.

Your Individual Rights Regarding Your Medical Information

Complaints. If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer at this practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized or discriminated against for filing a complaint.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations or to someone who is involved in your care or the payment for your care. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. To request restrictions, you must submit your request in writing to the Privacy Officer at this practice. In your request, you must tell us what information you want to limit and where in your records this information is contained.

Right to Request Confidential Communications. You have the right to request how we should send communications to you about medical matters, and where you would like those communications sent. To request confidential communications, you must make your request in writing to the Privacy Officer at this practice. We will not ask you the reason for your request. We will accommodate all reasonable requests, but reserve the right to charge you a cost-based fee for any non-customary expenses involved. Your request must specify how or where you wish to be contacted.

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records but does not include psychotherapy notes, information compiled for use in a civil, criminal or administrative action or proceeding, and protected health information to which access is prohibited by law. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer at this practice. If you request a copy of the information, we reserve the right to charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by this practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at this practice. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request. If the information was not created by us, is not part of the medical information kept at this practice, is not part of the information which you would be permitted to inspect and copy, or which we deem to be accurate and complete. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Statements of disagreement and any corresponding rebuttals will be kept on file and sent out with any future authorized request for information pertaining to the appropriate portion of your record.

Right to an Accounting of Non-Standard Disclosures. You have the right to request a list of the disclosure we made of medical information about you. To request this list, you must submit your request in writing to the Privacy Officer at this practice. Your request must state the time period for which you want to receive a list of disclosures that is no longer that six years, and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (example: on paper or electronically). The first list you request in writing within a 12-month period will be free. For additional lists, we reserve the right to charge you for the cost of providing the list.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice of Privacy Practices at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy. To obtain a paper copy of the current Notice, please request one in writing from the Privacy Officer at this practice.

Change to This Notice: We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post the current Notice, with the effective date in the upper right corner.

MEDICATION LIST
George M. Northrup, M.D.

Patient Name: ____

CURRENT MEDICATION	DOSAGE	REASON FOR MEDICATION

IN	DATE	MEDICATION	MG	DOSE	#	RF