Brian K. Wise, MD, MPH

7853 E. Arapahoe Court; #3550 Phone: 1.877.667.4366
Centennial, CO 80112 Fax: 1.877.676.9763

Pt's name: _____ Date of Appointment: _____

## Patient Information

Patient Name: _____
Date of Birth: _____/_____/_____ Age: _____ Social Security # _____-____-_____
Home Address: (No PO box #s) _____
City: _____ State: _____ Zip: _____
Cell Phone: _____ Home Telephone: _____Work Telephone: _____
At what number(s) may we leave a message? _____
Emergency Contact (Name and Phone): _____
Marital Status: □Single □Married □Divorced □Widowed
Referred by (Name/Phone/Address): _____

## Billing Information

Person responsible for payment: □SELF □Other _____ Date of Birth:_____
Address (include city/state/zip): _____
Cell Phone: _____ Home Telephone: _____Work Telephone: _____

Are you covered by medical insurance? □ No, I am Self-Pay (skip this section) □Yes (complete this section)
Do you have a co-pay? □No □Yes and it is $_____ Do you have a deductible? □No □Yes and it is $_____

**Primary Insurance Information:**
Insurance Company: _____ Phone # (____) _____
Address of Insurance Co.: _____ City_____State____Zip_____
Name of Policy Holder_____ Relationship to Patient _____
Identification no. _____ Group no. _____

**Secondary Insurance Information (if applicable):**
Insurance Company: _____ Phone # (____) _____
Address of Insurance Co.: _____ City_____State____Zip_____
Name of Policy Holder_____ Relationship to Patient _____
Identification no. _____ Group no. _____

## Office Policy

PAYMENT IS EXPECTED AT TIME OF APPOINTMENT. WE PARTICIPATE WITH MANY, BUT NOT ALL INSURANCE COMPANIES.

## IT IS YOUR RESPONSIBILITY TO DETERMINE IF WE ARE PARTICIPATING PROVIDERS OR NOT.

IF WE ARE NOT A PARTICIPATING PROVIDER WITH YOUR INSURANCE COMPANY AND YOU HAVE OUT OF NETWORK BENEFITS: THIS OFFICE IS NOT RESPONSIBLE FOR COLLECTING YOUR INSURANCE CLAIM OR FOR NEGOTIATING A SETTLEMENT ON A DISPUTED CLAIM. YOU ARE RESPONSIBLE FOR PAYMENT OF YOUR ACCOUNT. AT EACH VISIT, WE WILL PROVIDE YOU WITH A STATEMENT OF SERVICES THAT CONTAINS ALL THE INFORMATION YOU NEED TO FILE YOUR CLAIM WITH YOUR INSURANCE CARRIER.

## A FULL CHARGE OF OUR CLINICIAN'S STANDARD PROFESSIONAL FEES IS MADE IF A PATIENT DOES NOT SHOW FOR AN APPOINTMENT OR DOES NOT CANCEL THE APPOINTMENT WITH ADVANCE NOTICE OF LESS THAN 24 HOURS.

I HAVE READ THE ABOVE AND PROVIDED THE INFORMATION TO THE BEST OF MY KNOWLEDGE AND UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT.

_____ _____
Signature Patient Date

_____
Printed Name

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## ASSIGNMENT OF BENEFITS AGREEMENT

Our office will accept an assignment of benefits from your insurance company with the following provisions. It is important to understand, though, that the contract regarding your medical and mental health benefits is between you, your employer, and your insurance company. The obligation you have with our practice is to pay for treatment, regardless of the amount that may or may not be reimbursed by your insurance company. The following provisions identify our policies governing insurance claims.

- ✍ Although we are willing to complete insurance information forms and submit a claim on your behalf, we do not accept responsibility for the outcome of the transaction. Completing insurance forms is a courtesy we extend to you in an effort to maximize your insurance reimbursement. By having our office process your insurance forms, it is important that you understand that this does not eliminate your financial obligation for your treatment.
- ✍ We require you to sign this form and/or any other necessary assignment documents that may be required by your insurance company. This instructs your insurance company to make payment directly to our office.
- ✍ We require you to pay the co-payment, which is the amount not covered by your insurance company, at the time we provide service to you.
- ✍ Insurance payments ordinarily are received within 30-60 days from the time of billing. If your insurance company has not made payment to our office within 60 days, we will ask you to pay the balance due at that time. You will be responsible for seeking reimbursement from your insurance company at that time.
- ✍ Our office does not guarantee that your insurance company will pay for treatment you receive from our practice. We perform routine insurance billing procedures upon verification of coverage. However, if your claim is denied, you will be responsible for paying the full amount at that time.
- ✍ Our office will not enter into a dispute with your insurance company over any claim, although we will provide necessary documentation your insurance company requests to sort out any confusion or questions that may arise. We will cooperate fully with the regulations and requests of your insurance company. It is ultimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company.

**I HAVE READ AND UNDERSTAND THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY MEDICAL AND MENTAL HEALTH BENEFITS DIRECTLY TO THE PRACTICE.**

_____
Patient Name

_____ _____ _____
Name of Insurance Policy | Group # | Insurance Phone #

_____ _____ _____
Subscriber's Name | SSN or Subscriber ID | Subscriber's DOB

_____ _____
Signature of Parent/Responsible Party | Date

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# E-MAIL CORRESPONDENCE DISCLOSURE OF PROTECTED HEALTH INFORIVIATION

**Our office does send out complimentary reminders of upcoming appointments via e-mail.**

Our office offers **optional** e-mail correspondence to address after office hours questions and concerns regarding your mental health care including general inquiries about medications and treatment. The purpose of this option is **not to substitute** follow-up visits with the clinician, but to serve as an alternate means of communication with your mental health care provider. In reply to your e-mail, you may sometimes be instead instructed to follow up in our office to address your concerns if the provider recommends so based on his/her professional medical opinion.

The contents of the clinician's corresponding e-mails may include your personal health information. In relevance to your e-mail question or concern, this could include (but may not be limited to) your psychiatric diagnosis, prescribed medications, alcohol and drug history, and other medical diagnoses. Our office will **NOT** be held responsible for any individual who gains access to the contents of the corresponding e-mails regardless of the means by which it occurred.

If you are interested in our optional e-mail correspondence, complete the following appropriately. If not, **DO NOT FILL OUT THIS FORM**.

I, _____, agree to participate in the e-mail correspondence option.

I certify that I have read and understand the above information. If I decide to change my decision to participate in this option I agree to do so by notifying our staff and completing the bottom of this form, dating it, and returning it to our office.

My e-mail address is

_____@_____._____

_____ _____
Signature Date

---

I ***no longer agree*** to participate in the email correspondence option.

_____ _____
Signature Date

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## CUSTODIAL INFORMATION (IF APPLICABLE)

**Briefly Describe Custodial Arrangements (Parenting Time, Medical Decision Making Power, Payment):**

_____
_____
_____
_____
_____
_____

Due to the complexity of the marital structure and the implicit issues that arise during and following the process of a separation and divorce, it is required that a single adult be responsible for all appointments and billing.

If legal documents exist regarding custodial agreements it is required that a copy be on file with my office and that the identified parent responsible for scheduling and billing update this as required.

I understand that if I am unwilling or unable to follow this agreement, ongoing care will need to be transferred to an alternate treatment provider.

Primary Parent Contact:

Responsible for appointment scheduling and billing: _____

Preferred Contact Information: _____

Parent Signatures: _____ _____

Parent Names: _____ _____

Date: _____ _____

Witness(es): _____ _____

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Pt's name: _____ Date of Appointment: _____

Patient: _____ Gender: □F □ M Date of Birth:_____ Age: _____
Form completed by (if someone other than client): _____
Address: _____ City: _____ State: _____ Zip: _____
Phone (home): _____ (cell): _____ (work): _____
E-mail Address: _____

Primary reason(s) for seeking services:

| | | |
|---|---|---|
| ☐ Aggression | ☐ Elevated mood | ☐ Parenting Concerns/Issues |
| ☐ Alcohol dependence | ☐ Fatigue | ☐ Phobias/fears |
| ☐ Anger Management | ☐ Gambling | ☐ Recurring thoughts/Ruminations |
| ☐ Antisocial behavior | ☐ Hallucinations | ☐ Sexual addiction |
| ☐ Anxiety | ☐ Hopelessness | ☐ Sexual difficulties |
| ☐ Avoiding people | ☐ Hyperactivity | ☐ Sick often |
| ☐ Coping Skills | ☐ Impulsivity | ☐ Sleeping problems |
| ☐ Cyber addiction | ☐ Irritability | ☐ Speech problems |
| ☐ Depression | ☐ Judgment errors | ☐ Suicidal thoughts |
| ☐ Disorientation | ☐ Loneliness | ☐ Thoughts disorganized |
| ☐ Distractibility | ☐ Memory impairment | ☐ Traumatic experience(s) |
| ☐ Dizziness | ☐ Mood shifts | ☐ Tremors/Trembling |
| ☐ Drug dependence | ☐ Panic attacks | ☐ Withdrawing/Isolating |
| ☐ Eating disorder | ☐ Paranoia | ☐ Worrying |

Other mental health concerns (specify): _____

## Medical/Physical Health:

| | | |
|---|---|---|
| ☐ Seasonal Allergies | ☐ Sleeping disorders: _____ | ☐ Fibromyalgia |
| ☐ Anemia | ☐ Fainting | ☐ Epilepsy |
| ☐ Lupus | ☐ Sexual problems: _____ | ☐ Migraine Headaches |
| ☐ Arthritis | ☐ Thyroid problems | ☐ Neurological disorders:_____ |
| ☐ Asthma | ☐ Headaches (non-migraine) | ☐ Seizures |
| ☐ Bronchitis | ☐ COPD/Emphysema | ☐ Diabetes: ☐ Type 1 or ☐ Type 2 |
| ☐ Bed wetting | ☐ Hepatitis | ☐ Mononucleosis |
| ☐ Chronic pain | ☐ High blood pressure | ☐ Cancer: _____ |
| ☐ Heart Attack | ☐ Kidney problems: _____ | ☐ Head Trauma (w/ Loss of Consciousness): #_____ |

| YES (list below) | NO | ANY KNOWN DRUG/MEDICATION ALLERGIES? | | |
|---|---|---|---|---|
| **Medication** | | **Allergic Reaction** | **Medication** | **Allergic Reaction** |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

| YES (list below) | NO | ANY PAST SURGERIES? | | |
|---|---|---|---|---|
| **Surgery** | | **When? (Mo/Yr)** | **Surgery** | **When? (Mo/Yr)** |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

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## Family Information

Please give the names of family members and significant others in your life beginning with those living in your home currently.
Significant others may include: (e.g., brothers, sisters, grandparents, step-relatives, half-relatives. Please specify relationship.)

| Relationship | Name | Age | Living in Home | | Living | |
|---|---|---|---|---|---|---|
| | | | Yes | No | Yes | No |
| | | | | | | |
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## Current Marital Status: (more than one answer may apply)

*Assessment of current relationship (if applicable):* ☐ Great ☐ Good ☐ Average ☐ Poor ☐ Abusive

| | Marital Status | For How Long? (months/years) | | Marital Status | For How Long? (months/years) |
|---|---|---|---|---|---|
| | Single | | | Single; Stable Relationship | |
| | Married | | | Unmarried, Living Together | |
| | Divorced | | | Widowed | |
| | Separated | | | Annulled | |
| | | Total Number of Marriages Past and Present | | | |

## Parental Marital Information:

| Parental Marital Status | | For How Long? (months/years) | Parental Marital Status | |
|---|---|---|---|---|
| | Legally Married | | | Number of times Mother Married |
| | Parents Separated | | | Number of times Father Married |
| | Parents Divorced | | | |

Special circumstances (e.g., raised by person other than parents, information about spouse/children not living with you, etc.):

_____

_____

_____

## Education

| Highest Grade | # of Years | Graduate? | Degree? | Grades | Major(s): | 504? IEP?? |
|---|---|---|---|---|---|---|
| High School | | ☐ Y ☐ N | | As Bs Cs Ds | | |
| GED | | ☐ Y ☐ N | | As Bs Cs Ds | | |
| Vocational/Tech | | ☐ Y ☐ N | | As Bs Cs Ds | | |
| College | | ☐ Y ☐ N | | As Bs Cs Ds | | |
| Graduate School | | ☐ Y ☐ N | | As Bs Cs Ds | | |
| Professional | | ☐ Y ☐ N | | As Bs Cs Ds | | |

## Employment and Military Experience

### Current Employment Status:

☐ Full-time ☐Part-time ☐ Student ☐ Homemaker ☐ Disabled ☐ Retired ☐ Temp Work ☐Laid-off

Current Job Description:_____ Employer: _____

Past Job Description:_____ Employer: _____

Past Job Description:_____ Employer: _____

### Military Experience:

Military experience? ☐Yes ☐ No Combat experience? ☐ Yes ☐ No # Tours: _____ Where: _____

Branch: _____ Discharge date: ___/____Mo/Yr enlisted:___/___Type of discharge: _____ Rank at discharge:_____

## Legal

### Current Status

Are you involved in any active cases (traffic, civil, criminal)? ☐ No ☐Yes ~ Describe:_____ Are you presently on probation or parole? ☐ No ☐Yes

### Past History

Traffic violations: ☐ No ☐Yes ~ How Many? _____ DWAI, DUI, etc.: ☐No ☐Yes ~ How Many? _____

Criminal involvement: ☐ No ☐Yes ~ How Many? _____ Civil involvement: ☐ No ☐Yes ~ How Many? _____

| Charges/Arrests | Date (Mo/Yr) | Where (City/State) | Results |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

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## Leisure/Recreational

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, traveling, etc.)

| Activity | How often now? | What keeps you from doing the activity more than current? |
|---|---|---|
| | | |
| | | |
| | | |

## Spiritual/Religious

| How important to you is religion/spirituality? | None | | Little | Moderate | Very Much |
|---|---|---|---|---|---|
| Are you currently affiliated with a spiritual/religious group? | No | Yes | Describe: _____ | | |
| Were you raised within a spiritual/religious belief? | No | Yes | Describe: _____ | | |

## Abuse History

Are there special, unusual, or traumatic circumstances that affected your development? ☐ Yes ☐ No

If Yes, please describe: _____

| Type of Abuse: | Number of Separate Incidents | Age Started | Age Stopped | Reported? | Prosecuted? |
|---|---|---|---|---|---|
| Sexual – Physical – Emotional – Neglect | | | | | |
| Sexual – Physical – Emotional – Neglect | | | | | |
| Sexual – Physical – Emotional – Neglect | | | | | |
| Sexual – Physical – Emotional – Neglect | | | | | |
| Sexual – Physical – Emotional – Neglect | | | | | |
| Sexual – Physical – Emotional – Neglect | | | | | |

## Drug/Substance Use History

| Substance Use Abuse/Dependence History | Amount Used (drinks/cups/cigs/grams/ vials/bags/ # and mg of pills) | Frequency of Use (daily/weekly/monthly) | Age First Used | Age Last Used | Used Last 72 hours | | Used Last 30 days | |
|---|---|---|---|---|---|---|---|---|
| | | | | | Yes | No | Yes | No |
| Alcohol | | | | | | | | |
| Barbiturates | | | | | | | | |
| Benzodiazepines | | | | | | | | |
| Cocaine/Crack | | | | | | | | |
| Heroin/Opiates | | | | | | | | |
| Marijuana/THC/Weed | | | | | | | | |
| PCP/LSD/Mescaline | | | | | | | | |
| Inhalants | | | | | | | | |
| Caffeine | | | | | | | | |
| Nicotine | | | | | | | | |
| Over the counter | | | | | | | | |
| Prescription drugs | | | | | | | | |
| Other drugs | | | | | | | | |

Clean and Sober for how long? _____ months _____years

| | Drug/Substance(s) of Preference: | What do/did you like about the Drug/Substance? |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |

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**Please fill out the below medication history form as thoroughly as possible so that we can know what medications you have tried before and what effect they had on you. Although medications can be used for multiple reasons, it is helpful for us to know if you have been prescribed or tried any of these medications for any reason at all.**

| CHECK CURRENT MEDS | PAST MEDICATIONS | When | | Duration | | Dose/Day | | Response | Side Effects/Comments |
|---|---|---|---|---|---|---|---|---|---|
| **Mood Stabilizers** | | **Mo** | **Year** | **# Mos** | **# Years** | **Min** | **Max** | **+++/---** | **Side Effects/Comments** |
| | Lithium/Eskalith/Lithobid | | | | | | | | |
| | Depakote (ER)/Valproate | | | | | | | | |
| | Tegretol/Carbatrol | | | | | | | | |
| | Lamictal/Lamotrigine | | | | | | | | |
| | Trileptal/Oxcarbamazepine | | | | | | | | |
| | Topamax/Topiramate | | | | | | | | |
| | Gabapentin/Neurontin | | | | | | | | |
| **Antidepressants** | | **Mo** | **Year** | **# Mos** | **# Years** | **Min** | **Max** | **+++/---** | **Side Effects/Comments** |
| | Zoloft/Sertraline | | | | | | | | |
| | Lexapro/Escitalopram | | | | | | | | |
| | Celexa/Citalopram | | | | | | | | |
| | Prozac/Fluoxetine | | | | | | | | |
| | Paxil (CR)/Paroxetine | | | | | | | | |
| | Wellbutrin (SR) (XL) | | | | | | | | |
| | Cymbalta | | | | | | | | |
| | Effexor XR/Venlafaxine/Pristiq | | | | | | | | |
| | Remeron/Mirtazapine | | | | | | | | |
| | Emsam/Selegiline | | | | | | | | |
| | Parnate/Nardil | | | | | | | | |
| | Elavil/Amitriptyline | | | | | | | | |
| | Anafranil/Clomipramine | | | | | | | | |
| | Other: _____ | | | | | | | | |
| **Anxiolytics** | | **Mo** | **Year** | **# Mos** | **# Years** | **Min** | **Max** | **+++/---** | **Side Effects/Comments** |
| | Ativan/Xanax/Klonopin/Valium | | | | | | | | |
| | Buspirone/Buspar | | | | | | | | |
| | Vistaril | | | | | | | | |
| | Beta blocker/Inderal | | | | | | | | |
| **Antipsychotics** | | **Mo** | **Year** | **# Mos** | **# Years** | **Min** | **Max** | **+++/---** | **Side Effects/Comments** |
| | Risperdal and/or Invega | | | | | | | | |
| | Seroquel (XR)/Quetiapine | | | | | | | | |
| | Abilify/Aripipazole | | | | | | | | |
| | Geodon/Ziprasidone | | | | | | | | |
| | Zyprexa/Olanzapine | | | | | | | | |
| | Other: | | | | | | | | |
| **ADHD Meds/Stimulants** | | **Mo** | **Year** | **# Mos** | **# Years** | **Min** | **Max** | **+++/---** | **Side Effects/Comments** |
| | Adderall (XR) | | | | | | | | |
| | Vyvanse | | | | | | | | |
| | Dexedrine | | | | | | | | |
| | Concerta | | | | | | | | |
| | Daytrana patch | | | | | | | | |
| | Ritalin/Ritalin SR/Ritalin LA | | | | | | | | |
| | Focalin/Focalin XR | | | | | | | | |
| | Strattera | | | | | | | | |
| | Intuniv/Tenex | | | | | | | | |
| | Clonidine | | | | | | | | |
| | Provigil/Nuvigil | | | | | | | | |
| **Sleepers/Hypnotics** | | **Mo** | **Year** | **# Mos** | **# Years** | **Min** | **Max** | **+++/---** | **Side Effects/Comments** |
| | Ambien (CR) | | | | | | | | |
| | Lunesta | | | | | | | | |
| | Trazadone | | | | | | | | |
| | Remeron/Mirtazapine | | | | | | | | |
| | Sinequan/Doxepin | | | | | | | | |
| | Other: | | | | | | | | |
| **Others:** | | **Mo** | **Year** | **# Mos** | **# Years** | **Min** | **Max** | **+++/---** | **Side Effects/Comments** |
| | Aricept/Namenda/Exelon | | | | | | | | |
| | Thyroid Hormones | | | | | | | | |
| | Light Box | | | | | | | | |
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| FAMILY PSYCHIATRIC HISTORY | | Nuclear Family | | | | | | | Maternal Side | | | | | | Paternal Side | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | PATIENT | Mother | Father | Sister | Brother | Daughter | Son | | Grandmother | Grandfather | Aunt | Uncle | Cousin | UNKNOWN | Grandmother | Grandfather | Aunt | Uncle | Cousin | UNKNOWN |
| **Psychiatric Hospitalizations** | | | | | | | | | | | | | | | | | | | | |
| **Bipolar/Manic Depression** | | | | | | | | | | | | | | | | | | | | |
| **Depression** | | | | | | | | | | | | | | | | | | | | |
| **ADD/ADHD** | | | | | | | | | | | | | | | | | | | | |
| **Alcohol Abuse** | | | | | | | | | | | | | | | | | | | | |
| **Substance Abuse** | | | | | | | | | | | | | | | | | | | | |
| **Schizophrenia/Psychosis** | | | | | | | | | | | | | | | | | | | | |
| **Schizoaffective** | | | | | | | | | | | | | | | | | | | | |
| **Panic/Anxiety** | | | | | | | | | | | | | | | | | | | | |
| **Suicide Attempt** | | | | | | | | | | | | | | | | | | | | |
| **Suicide Completed** | | | | | | | | | | | | | | | | | | | | |
| **Developmental Delays** | | | | | | | | | | | | | | | | | | | | |
| **Suspected Mental Illness** | | | | | | | | | | | | | | | | | | | | |
| **Relative was Adopted** | | | | | | | | | | | | | | | | | | | | |
| **Other: _____** | | | | | | | | | | | | | | | | | | | | |
| **Other: _____** | | | | | | | | | | | | | | | | | | | | |
| **Other: _____** | | | | | | | | | | | | | | | | | | | | |

| | Past Types of Treatment | When Last Seen | | Duration | | Frequency | Response | Name/Comments of Past Psychotherapists/IOP/ PHP Hospital and/or ER Visits |
|---|---|---|---|---|---|---|---|---|
| | | Month | Year | # Mos | # Yrs | Xs/Mo | +++/--- | |
| | Psychiatrist (Meds) – First Time | | | | | | | |
| | Psychiatrist (Meds) – Last Time | | | | | | | |
| | Individual Therapy – First Time | | | | | | | |
| | Individual Therapy – Last Time | | | | | | | |
| | Family Therapy – First Time | | | | | | | |
| | Family Therapy – Last Time | | | | | | | |
| | Group Therapy – First Time | | | | | | | |
| | Group Therapy – Last Time | | | | | | | |
| | Intensive Outpatient - First | | | | | | | |
| | Intensive Outpatient - Last | | | | | | | |
| | Partial Hospitalization – First | | | | | | | |
| | Partial Hospitalization - Last | | | | | | | |
| | Inpatient Hospitalization – First | | | | | | | |
| | Inpatient Hospitalization - Last | | | | | | | |
| | Drug/Alcohol Rehab - First | | | | | | | |
| | Drug/Alcohol Rehab - Last | | | | | | | |
| | AA/Al-Anon/NA – First | | | | | | | |
| | AA/Al-Anon/NA – Last | | | | | | | |
| | ER Mental Health Visit - Last | | | | | | | |
| | Other: _____ | | | | | | | |
| | Other: _____ | | | | | | | |
| | Other: _____ | | | | | | | |
| | Other: _____ | | | | | | | |