Brian K. Wise, MD, MPH, ABIHM

6081 S. Quebec Street ~ Suite 100
Centennial, CO 80111

Phone: 720.253.0650
Fax: 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): _____
Email Address: (Used for Appointment Reminders/Billing) _____

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. _____

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

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 (or Legal Guardian) Date

_____
Printed Name

Brian K. Wise, MD, MPH, ABIHM

6081 S. Quebec Street ~ Suite 100
Centennial, CO 80111

Phone: 720.253.0650
Fax: 877.676.9763

Pt's name: _____ Date of Appointment: _____

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

Brian K. Wise, MD, MPH, ABIHM

6081 S. Quebec Street ~ Suite 100
Centennial, CO 80111

Phone: 720.253.0650
Fax: 877.676.9763

Pt's name: _____ Date of Appointment: _____

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

Brian K. Wise, MD, MPH, ABIHM

6081 S. Quebec Street ~ Suite 100
Centennial, CO 80111

Phone: 720.253.0650
Fax: 877.676.9763

Pt's name: _____ Date of Appointment: _____

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): _____

Brian K. Wise, MD, MPH, ABIHM

6081 S. Quebec Street ~ Suite 100
Centennial, CO 80111

Phone: 720.253.0650
Fax: 877.676.9763

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: _____
Referred by: _____

Primary reason(s) for seeking services:

☐ Aggression	☐ Elevated mood	☐ Parenting Concerns/Issues
☐ Argumentative	☐ Fatigue	☐ Phobias/fears
☐ Alcohol dependence	☐ Frustrated	☐ Recurring thoughts/Ruminations
☐ Anger	☐ Hallucinations	☐ Sexual addiction
☐ Anxiety	☐ Hopelessness	☐ Sexual difficulties
☐ Avoiding people	☐ Hyperactivity	☐ Sick often
☐ Coping Skills	☐ Impulsivity	☐ Sleeping problems
☐ Cyber addiction	☐ Irritability	☐ Self-Injurious Behaviors/Cutting
☐ Depression	☐ Judgment errors	☐ Suicidal thoughts
☐ Thoughts Racing	☐ 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): _____

Brian K. Wise, MD, MPH, ABIHM

6081 S. Quebec Street ~ Suite 100
Centennial, CO 80111

Phone: 720.253.0650
Fax: 877.676.9763

Pt's name: _____ Date of Appointment: _____

Medical/Physical Health:

□ General Symptoms: □ Weight Loss □ Weight Gain □ Fever □ Chills □ Fatigue □ "Wired and Tired" □ Chronic Pain

□ Eyes/Ears/Nose/Throat: □ Blurred/Worse Vision □ Sore Throat □ Ringing in ears □ Sinusitis □ Bloody Noses □ Eye Pain/Dry Eyes

□ Respiratory/Pulmonary: □ Asthma □ RAD □ Chronic Cough □ Shortness of Breath □ COPD/Emphysema

□ Cardiac/Vascular: □ Chest Pain □ Hypertension □ Heart Palpitations □ Syncope/Fainting □ Swelling/Edema □ Heart Attacks

□ Gastrointestinal: □ Nausea/Vomiting □ Diarrhea □ Constipation □ Reflux/GERD □ Encopresis □ Hepatitis B/C

□ Genitourinary: □ Enuresis □ Burning Urination □ Kidney Disease □ Erectile Dysfunction □ Loss of Labido □ Not able to Orgasm

□ Musculoskeletal: □ Muscle Aches □ Joint Aches □ Muscle Weakness/Hypotonia □ Joint Laxity/Hyperelasticity

□ Skin/Dermatologic: □ Acne □ Eczema/Dermatitis □ Rash □ Itching □ Bruises easily □ Vasculitis

□ Neurological: □ Seizures/Epilepsy □ Migraine Headaches □ Headaches □ Tremors □ Dizzy/Vertigo □ Concussions □ Head Trauma

□ Endocrine: □ Hypothyroid □ Diabetes I or II □ Adrenal Fatigue □ Always Cold □ Always Hot □ Hasimoto's Thyroiditis

□ Hematology/Oncology: □ Anemia □ Easily Bruise □ Blood Clots □ Swollen Glands □ History of Cancer – please list below

□ Rheumatologic/Autoimmune: □ Arthritis □ Fibromyalgia □ Lupus □ Chronic Fatigue

□ Allergy/Immunity: □ Sinusitis/Rhinitis □ Hives □ Immunodeficiency □ Sick Often □ Mold Exposure □ Chronic Fatigue

Other Doctors/Healthcare Providers with Name/Practice/Address/Phone/Fax

Primary Care Physician: _____
Other Doctors: _____
Other Doctors: _____
Other Doctors: _____
Other Doctors: _____

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

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

Brian K. Wise, MD, MPH, ABIHM

6081 S. Quebec Street ~ Suite 100 Phone: 720.253.0650
Centennial, CO 80111 Fax: 877.676.9763

Pt's name: _____ Date of Appointment: _____

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.)

NAME	Relationship	Age	Living in Home		Living	
			Yes	No	Yes	No

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??
Elementary School		☐ Y ☐ N		As Bs Cs Ds		
Middle School		☐ Y ☐ N		As Bs Cs Ds		
High School		☐ 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

Brian K. Wise, MD, MPH, ABIHM

6081 S. Quebec Street ~ Suite 100 Phone: 720.253.0650
Centennial, CO 80111 Fax: 877.676.9763

Pt's name: _____ Date of Appointment: _____

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
Were you raised within a spiritual/religious belief?	No	Yes	Describe: _____		
Are you currently affiliated with a spiritual/religious group?	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								
Other drugs								

Clean and Sober for how long? _____ Years _____Months

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

Brian K. Wise, MD, MPH, ABIHM

6081 S. Quebec Street ~ Suite 100
Centennial, CO 80111

Phone: 720.253.0650
Fax: 877.676.9763

Pt's name: _____ Date of Appointment: _____

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.

PAST MEDICATIONS TAKEN	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								
Lyrica								
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								
Brintillix								
Other: _____								
Anxiolytics	**Mo**	**Year**	**# Mos**	**# Years**	**Min**	**Max**	**+++/---**	**Side Effects/Comments**
Ativan/Xanax/Klonopin/Valium								
Buspirone/Buspar								
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								
Latuda/Lurasidone								
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/Guanfacine								
Clonidine								
Provigil/Nuvigil								
Sleepers/Hypnotics	**Mo**	**Year**	**# Mos**	**# Years**	**Min**	**Max**	**+++/---**	**Side Effects/Comments**
Ambien (CR)								
Lunesta								
Trazadone								
Melatonin								
Other:								
OTHER MEDS/SUPPLEMENTS	**Mo**	**Year**	**# Mos**	**# Years**	**Min**	**Max**	**+++/---**	**Side Effects/Comments**

Brian K. Wise, MD, MPH, ABIHM

6081 S. Quebec Street ~ Suite 100
Centennial, CO 80111

Phone: 720.253.0650
Fax: 877.676.9763

Pt's name: _____ Date of Appointment: _____

			Nuclear Family								Maternal Side							Paternal Side						
FAMILY PSYCHIATRIC HISTORY	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																								
Post-Traumatic Stress Disorder																								
Obsessive-Compulsive Disorder																								
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	# Yrs	# Mos	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: _____							