MERIDIAN
PSYCHIATRIC PARTNERS

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Gender Listed on Insurance:
Female ☐ Male ☐

LEGAL NAME

Female ☐ Male ☐ Other ☐

PREFERRED NAME AND GENDER (if different from above)

SSN | BIRTHDATE | AGE

ADDRESS

CITY | STATE | ZIP

Ok to leave a voicemail? Yes ☐ No ☐

HOME PHONE | WORK PHONE | MOBILE PHONE

EMAIL

RELATIONSHIP STATUS: ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Separated ☐ Widowed

EMERGENCY CONTACT INFORMATION

NAME | RELATIONSHIP | PHONE NUMBER

EMPLOYER INFORMATION

EMPLOYER NAME | OCCUPATION

EMPLOYER ADDRESS | EMPLOYER PHONE NUMBER

REFERRED BY

NAME | EMAIL | PHONE NUMBER

INSURANCE CARRIER INFORMATION (Choose One)

☐ BCBS PPO ☐ Aetna PPO ☐ Aetna POS ☐ Self-Pay

PATIENT/GUARDIAN SIGNATURE | DATE

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MERIDIAN
PSYCHIATRIC PARTNERS

PATIENT REGISTRATION FORM

ACKNOWLEDGEMENT OF BILLING POLICY

- Payment is due at the time of service.
- Payment may be made by Cash, Check or Credit Card.
- You must provide a credit card number to be kept on file. In the event that a balance is outstanding more than 60 days, this card will be automatically charged.
- Once an account is more than 90 days past due, it is subject to Collections action.
- The fees for the Initial Evaluation and subsequent sessions are as discussed at intake or with your clinician.
- Statements for outstanding balances are generated monthly.
- If your check is returned NSF (non-sufficient funds), a $30 charge will be added to the outstanding balance.
- It is your responsibility to provide the office with up-to-date billing information, including changes to address, credit card, and Insurance information.
- Meridian will only bill directly to our Contracted Provider Plans.

CANCELLATION POLICY

At least 24 business hours' notice of cancellation is required to avoid being charged the cancellation fee. If you do not cancel your appointment within the 24 business hour requirement, you will be charged the **FULL FEE** ($200, $150 OR $125 depending on the type of appointment and provider) **Cancellation fees cannot be billed to Insurance**.

SIGNATURE

I have read the above information and agree with these conditions.

PATIENT/GUARDIAN SIGNATURE _____ DATE _____

APPOINTMENT REMINDER

☐ Text ☐ Phone ☐ Email: _____ PT Initials: _____

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MERIDIAN
PSYCHIATRIC PARTNERS

PATIENT REGISTRATION FORM

INSURANCE

- Insurance Cards are required at every visit. We will verify your insurance coverage at the time of your first visit if possible.
- Depending on your insurance, Meridian will be reimbursed based on a percentage of the amount billed. We do not know the exact amount until we receive payment. All co-payments, deductibles, and payments for non-covered services are due at the time of the service or when balances become known. As the recipient of services, you are ultimately responsible for all services provided. Not all services may be covered by insurance, and you will be fully responsible for those uncovered charges. Meridian is under no obligation to pursue reimbursement on the patient's behalf.
- If payment from your Insurance Provider is not received in full within thirty (30) days after submission of the request for payment, it is your responsibility to pay. If payment is not received in full within sixty (60) days, by providing your credit card and receiving provided services, you are authorizing Meridian to charge your provided credit card for any unpaid bills or claims. Without a card on file, payment is due in full at the time services are rendered. Any claims paid after your credit card has been billed will be refunded to you.

If you are covered by either a Blue Cross/Blue Shield PPO, Aetna PPO, or Aetna POS plan:

- We will bill at an in-network level for those plans.
- It is your responsibility to contact your insurance carrier to discuss your plan's mental health benefits, including any deductibles, co-payments, annual and lifetime limits, **and if pre-authorization is required**. We will bill the carrier for you.
- Your co-pay is due at the time of service.
- You are responsible for all charges not paid by your insurance, including deductibles, co-payments, any uncovered charges, charges for missed appointments, etc.
- You are responsible for informing the front desk of any changes to your insurance coverage.

If you are covered by an Out of Network Provider Plan:

- The out of pocket payment is **due at the time of service**.
- After payment has been made and applied towards the billed services, we will provide you with an Insurance Invoice to submit to your insurance plan.

SIGNATURE

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above mentioned Health Insurance Providers, and hereby assign and convey directly to Meridian all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments.

PATIENT/GUARDIAN SIGNATURE DATE

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MERIDIAN
PSYCHIATRIC PARTNERS

PATIENT REGISTRATION FORM

MERIDIAN CREDIT CARD AUTHORIZATION

I, _____ hereby authorize Meridian Psychiatric Partners, LLC, to charge my credit/debit card for any account balance that is more than 60 days past due.

Patient Initials: _____

I understand my card will be charged on a regular basis for these amounts. I also understand that in the event that my card is declined, I will be required to provide a different method of payment. I will also be expected to pay for any previously unpaid charges resulting from the decline, in addition to the current charges.

I authorize my card to be charged for fees as indicated above.

Patient Initials: _____

CREDIT CARD INFORMATION

CREDIT CARD NUMBER | EXP. DATE | CVV CODE

BILLING ADDRESS (for the Debit/Credit Card listed above)

CITY | STATE | ZIP

PATIENT NAME (please print) | PATIENT/GUARDIAN SIGNATURE | DATE

AUTOMATIC BILLING

Additionally, for your convenience, if you wish to have your balance charged to your credit/debit card for any patient responsibility from services rendered (deductibles, co-payments, and co-insurances) and/or fees incurred (cancellations within 24 hours or no-show appointments) after each visit, please check the auto charge box and initial below.

☐ **YES**, charge this credit card for my balance regularly.

Patient Initials: _____

STATEMENT INFORMATION

You will receive statements from Meridian Psychiatric Partners by U.S. Mail or email (unless otherwise requested).

PATIENT/GUARDIAN SIGNATURE | DATE

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NOTICE OF PRIVACY PRACTICES

This notice describes how Mental Health information about you may be used and disclosed, and how you can get access to this information. Please read it carefully.

REGARDING MENTAL HEALTH INFORMATION

The privacy of your (i.e. you and your child's) mental health information is important to us. We understand that your mental health information is personal and we are committed to protecting it. We create a record of the care and services you receive at our practice. We need this record to provide you with quality of care and continuity of care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share mental health information about you. We also describe your rights and certain duties we have regarding the use and disclosure of mental health information.

OUR LEGAL DUTY

The law requires us to:

- Keep your mental health records private.
- Give you this notice describing our legal duties, privacy practices, and your rights regarding your mental health records.

We have the right to:

- Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
- Make the privacy practices and the new terms of our notice effective for all mental health records that we keep, including information previously created or received before the changes.

NOTICE OF CHANGE TO PRIVACY PRACTICES

Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

USE AND DISCLOSURE OF YOUR MENTAL HEALTH INFORMATION

The following section describes different ways that we use and disclose mental health information. For each kind of use or disclosure, we will explain what we mean and give an example. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose mental health information. We will not use or disclose your mental health information for any purpose not listed below without your specific authorization. Any specific written authorization you provide may be revoked at any time by writing to us. Revocation will not apply to information that has already been released.

For Treatment/Evaluation:

We may use mental health information about you or your child to provide you with psychiatric, psychotherapy or evaluation services. We may disclose mental health information about you to your primary care physician if it is required by your insurance or managed care company. Also, we may disclose mental health information about you to a referring or referred mental health provider if you require additional services. From time to time, it is helpful for us to consult with other professionals regarding your treatment. In such events, our consultants are also legally bound by the privacy practice policies.

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For Payment:

We may use and disclose your mental health records for payment purposes. We may need to supply your health insurance plan with information about treatment you received at our practice so that your health plan will pay for services that were incurred. We may also tell your health plan about a treatment that you are going to receive to get approval or to determine if your plan will pay for the treatment.

Business Associates:

We may also disclose your health information to third-party business associates (for example, an accounting firm or billing company) that perform activities or services on our behalf. Each business associate must agree in writing to protect the confidentiality of your information.

Additional Uses and Disclosures:

In addition to using and disclosing your mental health information for treatment, payment, and health care operations, we may use and disclose mental health information without your authorization, consent or opportunity to object for the following purposes:

- **Notify or help notify a family member, a personal representative, or another person responsible for your care about your location, general condition, or death**. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of an emergency and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgement.
- **Required by Law**. We may use or disclose your health information to the extent that the use or disclosure is required by federal, state or local law, but only to the extent and under the circumstances provided in such law.
- **Specialized Government Functions**. Subject to certain requirements, we may disclose or use your mental health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for governmental programs providing public benefits.
- **Court Orders and Judicial and Administrative Proceedings**. We may disclose your mental health records in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your mental health records with law enforcement officials concerning the mental health records of a suspect, fugitive, material witness, crime victim, or missing person.
- **Public Health Activities**. As required by law, we may disclose your mental health records to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also, when we are authorized by law to do so, notify a person who was exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.
- **Victims of Abuse, Neglect, or Domestic Violence**. We may disclose your records to appropriate authorities if we have reason to believe that you are a possible victim of abuse, neglect, or domestic violence, or the possible victim of other crimes. We may share your mental health records if it is necessary to prevent a serious threat to your health or safety or the health and safety of others.
- **Health Oversight Activities**. We may disclose your mental health records to any agency providing health oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure, or disciplinary actions, or other authorized activities.

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YOUR INDIVIDUAL RIGHTS

- You have the right to look at or receive copies of your mental health records. You must make your request in writing. You may request access by sending your request to the contact person(s) listed at the end of this notice. For evaluations, raw data (i.e., test forms/responses) can only be released to a qualified mental health professional. If you request copies, there will be a $1.00 per page fee. There is also an additional postage charge if you want the copies mailed to you. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.
- You have the right to receive a list of all of the times we or our business associates shared your records for purposes other than treatment, payment and health care operations and other specified exceptions.
- You have the right to request that we place additional restrictions on our use or disclosure of your records. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
- You have the right to request that we communicate with you about your mental health information by different means or to different locations. Your request that we communicate your mental health records to you by different means or at different locations must be made in writing to the contact person(s) listed at the end of this notice.
- You have the right to request that we change your mental health record information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you with a written explanation. You may reply with a statement of disagreement that will be added to the information that you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others of the change, including people you name, and to include the changes in any future sharing of the information.
- If you have received this notice electronically and wish to receive a paper copy, you have the right to obtain a paper copy by making a request to the contact person(s) listed at the end of this notice.

QUESTIONS AND COMPLAINTS

If you have any questions about this notice, please contact:

Meridian Psychiatric Partners, L.L.C.
ATTN: Dr. Flavio Arana, Director
625 N. Michigan Ave., Ste: 2550, Chicago, IL 60611

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (“HIPAA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and clinician certifications.

I have received, read and understood your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the “Notice of Privacy Practices”.

SIGNATURE

PATIENT/GUARDIAN SIGNATURE DATE

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MERIDIAN
PSYCHIATRIC PARTNERS

RELEASE OF INFORMATION

AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT INFORMATION:

PATIENT'S NAME _____ BIRTHDATE _____

ADDRESS _____ PHONE NUMBER _____

CITY _____ STATE _____ ZIP _____

MAIDEN/OTHER NAMES _____

I authorize the use/disclosure of my mental health records and/or information to:

NAME _____ PHONE NUMBER _____

ADDRESS _____ FAX NUMBER _____

CITY _____ STATE _____ ZIP _____

This authorization is limited to the following specific types of information:

☐ Date(s) of Treatment From: _____ to _____ or a specific date: _____

DESCRIPTION OF MY MENTAL HEALTH RECORDS AND/OR INFORMATION TO BE DISCLOSED:

☐ Hospital Consult –Psychology/Psychiatry/Neuropsychology
☐ Office Visit –Psychology/Psychiatry/Neuropsychology
☐ Hospital Progress Notes –Psychology/Psychiatry/Neuropsychology
☐ Neuropsychological Evaluation and Testing Data/Results
☐ Testing Data – Psychology/Psychiatry
☐ Labs
☐ X-Ray
☐ Billing Records
☐ Other: _____

SPECIALLY PROTECTED RECORDS:
(Check and Initial the following)
☐ Alcohol/Drug Abuse _____
☐ Genetics _____
☐ HIV/AIDs _____

If you are authorizing the disclosure of psychological tests, such tests may only be disclosed to a psychologist that you have designated.

(CONTINUED)

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MERIDIAN
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RELEASE OF INFORMATION

AUTHORIZATION FOR RELEASE OF INFORMATION (CONTINUED)

Information is being released for the purpose of:

☐ Treatment coordination/planning

☐ Other: _____

I understand that:

☐ This consent will automatically expire one year from signing unless a different date of expiration is specified here:

_____
DATE

☐ I have the right to copy and inspect the information being disclosed.

☐ This information may be transmitted via written word, facsimile, or over the phone.

Restrictions if any: _____

☐ Authorization for this release of information can be revoked at any time. To revoke this authorization, I understand that I must provide a statement in writing with my request. Revocation will not apply to information that has already been released.

☐ I understand that the person or agency who receives my mental health information, genetic testing, alcohol and drug abuse records or HIV/AIDs records may NOT disclose it to someone else without my specific permission, unless permitted by law.

☐ If I refuse to consent to the release of information specified above, information will not be disclosed/obtained.

☐ I may be charged a copying fee to complete this request.

SIGNATURE

PATIENT SIGNATURE (AGE 12 OR OLDER) DATE

PARENT/GUARDIAN OR OTHER AUTHORIZED AGENT SIGNATURE (IF APPLICABLE) DATE

PRINTED NAME OF PARENT/GUARDIAN OR OTHER AUTHORIZED AGENT (IF APPLICABLE) RELATIONSHIP TO PATIENT

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MERIDIAN
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GOOD FAITH ESTIMATE

To Meridian Patients:

In compliance with the **No Surprises Act** that went into effect January 1, 2022, all healthcare providers including psychiatrists and therapists are required to notify clients of their federal rights and protections against "surprise billing." The purpose of the Act and of this document is to protect you from unexpected medical bills.

This Act requires that we notify you of your federally protected rights to receive a notification when services are rendered by an out-of-network provider, if you are uninsured, or if you elect not to use your insurance.

In case any of these situations apply to you, we are required to let you know that you may request a "Good Faith Estimate" of the cost of services to you. Providing this estimate is challenging in mental health care because it is difficult to predict the length of treatment, and because clients have a right to decide how long they want to participate. Therefore, we describe below the fees that typically apply for the types of services offered, including for your condition. Going forward, we can collaborate on a regular basis to determine how many sessions you may need.

Meridian current fee schedule:

- Initial diagnostic, psychiatric evaluation with a psychiatrist or nurse practitioner (usually 45-60 minutes, CPT codes 90792, 99203, 99204, 99205, 90833, 90836, 90838): $425.
- 30 minutes of medication management (CPT codes 99213, 99214, 99215, 90833): $220.
- 55-60 minutes of psychotherapy (individual, couple, or family) with or without medication management with a psychiatrist or nurse practitioner (CPT code 90837): $225.
- Initial diagnostic, psychiatric evaluation with a therapist (usually 45-60 minutes, CPT codes 90791): $375.
- 50-60 minutes of psychotherapy (individual, couple, or family) with a therapist (CPT code 90834, 90837, 90846, 90847): $225.
- 30 minutes of psychotherapy (individual, couple, or family) with a therapist (CPT code 90832): $135.
- These fees apply to all DSM diagnostic codes of the American Psychiatric Association.
- We use diagnostic codes that are clinically accurate, but these do not guarantee reimbursement.
- Most often therapy is done weekly, but sometimes more or less often. Standard therapy sessions are 50-60 minutes.
- Most often therapy continues for six months, one year, or several years, but short-term, brief therapy for intercurrent issues is also common. As noted above, because of this variability, please ask your provider about what can be expected in your case.
- Most often medication management is done every three months, but usually more often at the beginning of treatment and during periods of acuity, and sometimes less often.
- Most often medication management continues for several years or even longer; because of this variability, please ask your provider what can be expected in your case.
- It is your right to determine your goals for treatment and how long you want to remain in therapy.

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MERIDIAN
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GOOD FAITH ESTIMATE

DISCLAIMER

This Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs for an item or service. The estimate is based on information known at the time the estimate was created.

The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. If this happens, federal law allows you to dispute (appeal) the bill.

If you are billed for more than this Good Faith Estimate, you have the right to dispute the bill.

You may contact Meridian to let us know the billed charges are higher than the Good Faith Estimate. You can ask us to update the bill to match the Good Faith Estimate, ask to negotiate the bill, or ask if there is financial assistance available.

This good faith estimate is not a contract and does not require you to obtain services from any of the providers with Meridian.

You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (about 4 months) of the date on the original bill.

There is a $25 fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate. If the agency disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount.

To learn more and get a form to start the process, go to www.cms.gov/nosurprises or call the number below.

Should you have additional questions about your rights under this act, you can contact any of the following:

The **U.S. Centers for Medicare & Medicaid Services** (CMS) at **1- 800-MEDICARE** (1-800-633-4227) or visit www.cms.gov/nosurprises for more information about your rights under federal law. **The Illinois Department of Insurance**, Office of Consumer Health Insurance at **(877) 527-9431**.

Keep a copy of this Good Faith Estimate in a safe place or take pictures of it. You may need it if you are billed a higher amount.

It is a federal requirement that each client sign this form to begin/continue treatment.

Please sign before your next appointment.

SIGNATURE

SIGNATURE DATE

PRINT NAME

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MERIDIAN
PSYCHIATRIC PARTNERS

INFORMED CONSENT: TELEMEDICINE SERVICES

PATIENT INFORMATION

PATIENT NAME | BIRTHDATE | DATE

☑ I understand that this Telemedicine Consent Form is extended to include all providers at Meridian Psychiatric Partners.

Telemedicine is the use of electronic information and communication technologies by a healthcare provider to deliver services to an individual when he/she is located at a different location than the healthcare provider. This may be for the purpose of diagnosis, treatment, follow-up and/or education. During your telemedicine consultation, details of your medical history and personal health information may be discussed with you or other health professionals through the use of interactive video, audio or other telecommunications technology. Additionally, a physical examination of you may take place, and video, audio, and/or photo recordings may be taken.

All efforts will be made to utilize electronic systems with network and software security protocols to protect the privacy and security of health information and to safeguard the data against corruption. However, the mode of communication used during telehealth consultation has the potential to be less secure than in person consultation and may be subject to additional privacy risks.

ANTICIPATED BENEFITS

- Improved access to medical care by enabling a patient to remain in his/her location while the healthcare provider provides care from a distant site
- Limiting the spread of airborne diseases
- More efficient medical evaluation and management
- Ability to obtain consultation of a distant specialist
- Conservation of personal protective equipment such as gloves and masks to reduce shortages for healthcare providers

POSSIBLE RISKS

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- In rare cases, it may be determined that the information transmitted is of poor quality, requiring a face to face visit or rescheduled telemedicine visit. This may cause a delay in medical evaluation/treatment.
- Security protocols could fail or not be available, causing a breach of privacy of personal medical information.
- In rare cases, a lack of access to all of your medical records may result in adverse drug interactions or allergic reactions or other judgment errors.

BY SIGNING THIS FORM, I UNDERSTAND THE FOLLOWING:

1. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed.
2. I understand that all efforts will be taken to protect the privacy and security of health information, and that no information obtained in the use of telemedicine which identifies me will be intentionally disclosed to researchers or other entities without my authorization.
3. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time without affecting my right to future care or treatment.

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4. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. My healthcare provider has explained the alternative to my satisfaction.
5. I understand that the telemedicine visit may occur with a licensed medical provider who is not licensed in my state of residence. I also understand there may be electronic communication of my personal medical information to other medical providers who may be located in other states.
6. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. The above-mentioned people will all maintain confidentiality of the information obtained.

PATIENT CONSENT TO THE USE OF TELEMEDICINE

I have read and understand the information provided above regarding telemedicine. I have discussed and had an opportunity to ask my healthcare provider questions. All of these questions have been answered to my satisfaction.

SIGNATURE

☑ I hereby **AUTHORIZE** Meridian Psychiatric Partners to use telemedicine in the course of my diagnosis and treatment.

☐ I hereby **REFUSE** Meridian Psychiatric Partners to use telemedicine in the course of my diagnosis and treatment.

PATIENT/GUARDIAN SIGNATURE _____ DATE _____

RELATIONSHIP TO PATIENT (IF GUARDIAN SIGNATURE) _____

WITNESS _____ DATE _____

☐ I have been offered a copy of this consent form (patient's initials) _____

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MERIDIAN
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PATIENT MEDICAL HISTORY

PATIENT INFORMATION

NAME (First, Middle, Last) HEIGHT WEIGHT

Reason for today's visit:

Medication allergies (symptoms of allergic reaction):

Current prescription and over-the-counter medications (provide doses, if possible):

Past medications tried for treatment of a mental health condition or insomnia (doses, if you recall):

Primary Care Physician

NAME ADDRESS PHONE NUMBER

Current Psychiatrist (if applicable)

NAME ADDRESS PHONE NUMBER

Current Therapist

NAME EMAIL

ADDRESS PHONE NUMBER

Medical conditions you have been treated for:

Covid Vaccination Status: ☐ Not Vaccinated ☐ One Dose ☐ Two Doses ☐ Boosted

Psychiatric hospitalizations (reason, location, and dates if possible):

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PATIENT MEDICAL HISTORY

Suicide attempts (dates, if possible):

Substance use disorder treatment (dates and location, if possible):

Family history of psychiatric illness (please list family member and known diagnosis):

Please look at the list of physical symptoms below and check off any that you have experienced in the last SEVERAL DAYS:

- ☐ Chronic pain
- ☐ Loss of appetite
- ☐ Increase in appetite
- ☐ Unexplained weight loss
- ☐ Weight gain
- ☐ Fatigue/Lethargy
- ☐ Unexplained fever
- ☐ Hot or cold spells
- ☐ Night sweats
- ☐ Sleeping pattern disruption

- ☐ Eye pain
- ☐ Blurred or double vision
- ☐ Visual change
- ☐ Retinal hemorrhage (floaters in vision)
- ☐ Tinnitus (ringing in ears)
- ☐ Decreased hearing or hearing loss
- ☐ Frequent nose bleeds
- ☐ Difficulty swallowing
- ☐ Teeth grinding/clenching at night
- ☐ Dry mouth

- ☐ Joint pains or stiffness
- ☐ Muscle pain or cramping
- ☐ Muscle weakness
- ☐ Back pain or stiffness

- ☐ Chest pain
- ☐ Pacemaker placement
- ☐ Palpitations (fast or irregular heartbeat)
- ☐ Swollen feet or hands
- ☐ Fainting spells
- ☐ Shortness of breath with mild exercise
- ☐ Chronic cough
- ☐ Chronic shortness of breath
- ☐ Chronic wheezing/Asthma
- ☐ Coughing blood

- ☐ Frequent diarrhea
- ☐ Frequent constipation
- ☐ Persistent nausea or vomiting
- ☐ Abdominal pain
- ☐ Frequent heartburn (GERD)
- ☐ Blood in stool
- ☐ Dark/Tarry stools

- ☐ Frequent infections
- ☐ Hives
- ☐ Cold or heat intolerance
- ☐ Excessive thirst or urination
- ☐ Excessive/Easy bruising

- ☐ Painful/Burning urination
- ☐ Urine retention

- ☐ Dizziness/Vertigo
- ☐ Short-term memory difficulties
- ☐ Frequent headaches
- ☐ Numbness/Tingling sensations
- ☐ Tremors in hands/shaking
- ☐ Muscle spasms or tremors

- ☐ Rashes
- ☐ Hair or nail changes
- ☐ Hair loss

- ☐ Feeling depressed
- ☐ Difficulty concentrating
- ☐ Phobias/Unexplained fears
- ☐ No pleasure from life anymore
- ☐ Panic attacks or frequent anxiety
- ☐ Frequent insomnia
- ☐ Excessive moodiness
- ☐ Confusional states
- ☐ Frequent nightmares

625 North Michigan Avenue, Suite 2550, Chicago, IL, 60611 Phone: 312-640-7740 Fax: 312-640-7736 www.meridianpsychiatricpartners.com

MERIDIAN
PSYCHIATRIC PARTNERS

CONSENT TO OBTAIN MEDICATION HISTORY

Meridian Psychiatric Partners has adopted an electronic medical record system in order to improve the quality of our services. This system also allows us to collect and review your "medication history." A medication history is a list of prescription medicines that we or other doctors have recently prescribed for you. This list is collected from a variety of sources, including your pharmacy and your health insurer.

An accurate medication history is very important to helping us treat you properly and in avoiding potentially dangerous drug interactions.

By signing this consent form you give us permission to collect, and give your pharmacy and your health plan permission to disclose, information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medications to treat AIDS/HIV and medicines used to treat mental health conditions, such as depression. This information will become part of your medical record.

This medication history is a useful guide, but it may not be completely accurate. Some pharmacies do not make drug history available to us, and the drug history from your health plan might not include drugs that you purchased without using your health insurance. Your medication history might not include over-the-counter medicines, supplements or herbal remedies. It is still very important for us to take the time to discuss everything you are taking, and for you to point out to us any errors in your medication history.

☐ **I give permission for Meridian Psychiatric Providers to obtain my medication history from my pharmacy, my health plans and my other healthcare providers.**

☐ **I DO NOT give permission for Meridian Psychiatric Providers to obtain my medication history from my pharmacy, my health plans and my other healthcare providers.**

SIGNATURE

PATIENT NAME _____ DATE OF BIRTH _____

PATIENT SIGNATURE _____ DATE _____

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