MICHIGAN STATE UNIVERSITY
DEPARTMENT OF PSYCHIATRY

Thank you for your interest in Michigan State University's Psychiatric Services. A service of the Department of Psychiatry and the MSU HealthCare.

The enclosed packet of material needs to be completed and returned to our office before an appointment can be scheduled. Obtaining as much information as possible regarding your history will assist us in performing an accurate and thorough assessment. Please complete the enclosed forms as accurately and completely as possible and return them in the enclosed envelope.

If you have been under the care of a psychiatrist or had any psychiatric hospitalizations within the past year, please have those records forwarded to us.

We will ask you to sign a Patient Authorization for Disclosure of Health Information for your primary care physician in order to coordinate care.

The Department of Psychiatry is a training institution. You will be scheduled with a Resident who is supervised by a licensed Psychiatrist. Note that a medical student may be observing in your care.

Thank you for your prompt consideration. If you have any questions, please feel free to contact us at (517) 353-3070.

Psychiatry
West Fee Hall
909 Wilson Road
Suite B119
East Lansing, MI 48824
(517) 353-3070
Fax: (517) 884-1817
healthcare.msu.edu
psychiatry.msu.edu

Nikki Peterson
Intake Coordinator
Department of Psychiatry
Michigan State University
Telephone: 517-353-3070 Fax: 517-884-1817

Michigan State University Health Care does not discriminate on the basis of race, color, national origin, sex, age, or disability in its health program or activities.
Patient Registration

Last Name: ___________________________ First Name: ___________________________

First Name Used: ___________________ DOB: __________ SSN: __________

Legal Sex: __________ Assigned at birth: __________ Gender Identity: __________

Preferred Pronoun: □ he/him □ she/her □ they/them

Sexual Orientation: □ Lesbian or gay or homosexual □ Straight or heterosexual □ Bisexual □ Something else □ Don't know □ Choose not to disclose

Street Address: ___________________________________________________________

City: ___________________________ State: __________ Zip: __________

Phone Number: ___________________________ Secondary Number: __________

Email (Not parent email if minor): _________________________________________

Language Preference: _________________________________________

Race: ___________________________ Ethnicity: ___________________________

Marital Status: ___________________________

PRIMARY INSURANCE

Holder: ___________________________

Group #: ___________________________

Policy: ___________________________

EMERGENCY CONTACT

Name: ___________________________

Relation: ___________________________

Phone Number: ___________________________

Secondary Number: ___________________________

PARENT/GUARDIAN(S)

Parent/Guardian #1 Name: ___________________________

Phone: ___________________________ Email: ___________________________

Street Address (if different than patient): ___________________________

City: ___________________________ State: __________ Zip: __________

Parent/Guardian #2 Name: ___________________________

Phone: ___________________________ Email: ___________________________

Street Address (if different than patient): ___________________________

City: ___________________________ State: __________ Zip: __________

SECONDARY INSURANCE

Holder: ___________________________

Group #: ___________________________

Policy: ___________________________

NEXT OF KIN

Name: ___________________________

Relation: ___________________________

Phone Number: ___________________________

Secondary Number: ___________________________

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June 2020
GEROPSYCHIATRY
Patient Information Form

IDENTIFYING DATA:

Name ________________________________ Age _____
Address __________________________________________________________________________
Telephone No.: ____________________________________________________________________
Guardian/Power of Attorney: ________________________________________________________________________
Reason for Seeking Treatment: ________________________________________________________________

________________________________________________________________________________________

Referral Source: __________________________________________________________________________

PREVIOUS PSYCHIATRIC TREATMENT:

Date: ________________________________
Type of Treatment: __________________________________________________________________________

________________________________________________________________________________________

Date: __________________________________
Type of Treatment: ________________________________

________________________________________________________________________________________
MEDICAL HISTORY:

Current Physician: ____________________________

Address: ____________________________________

Current Medical Problems: ____________________

___________________________________________

___________________________________________

Current Medications:

<table>
<thead>
<tr>
<th>Name</th>
<th>Strength</th>
<th>Dosage Schedule</th>
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Past Surgeries:

___________________________________________

___________________________________________

___________________________________________

___________________________________________
DRUG & ALCOHOL USE:

History of Substance Abuse: __________________________

Length of Time Substance Used: __________________________

Amount Per Day: __________________________

FAMILY HISTORY:

Mother’s Name: __________________________

Quality of Relationship: __________________________

Year / Cause of Death: __________________________

Father’s Name: __________________________

Quality of Relationship: __________________________

Year / Cause of Death: __________________________

Number of Brothers: ______ SISTERS: ______

Names (Brothers): __________________________

Names (Sister): __________________________

Quality of Relationship: __________________________

Family History of Psychiatric Illness: __________________________

Family History of Suicide: __________________________
Family History of Substance Abuse: ________________________________

MARITAL HISTORY:

Marital Status: M S D W SEP

Spouse Name: ________________________________

Quality of Relationship: ________________________________

Previous Marriages (Relationships):

Quality of Relationship: ________________________________

Children:

<table>
<thead>
<tr>
<th>Names</th>
<th>Quality of Relationship</th>
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SOCIAL HISTORY:

Education Level: ________________________________

Employment: ________________________________

Military History: ________________________________

Involvement With Legal System: ________________________________

Hobbies: ________________________________
The Geriatric Depression Scale – short form (GDS)

Date ________________________  Pt.# ______________________

Choose the best answer for how you felt over the past week.

1. Are you basically satisfied with your life?  Yes/ No

2. Have you dropped many of your activities/interests?  Yes/No

3. Do you feel that your life is empty?  Yes/No

4. Do you often get bored?  Yes/No

5. Are you in good spirits most of the time?  Yes/No

6. Are you afraid that something bad is going to happen to you?  Yes/No

7. Do you feel happy most of the time?  Yes/No

8. Do you often feel helpless?  Yes/No

9. Do you prefer to stay home, rather than going out & doing new things?  Yes/No

10. Do you feel you have more problems with memory than most people?  Yes/No

11. Do you think it is wonderful to be alive now?  Yes/No

12. Do you feel pretty worthless the way you are now?  Yes/No

13. Do you feel full of energy?  Yes/No

14. Do you feel that your situation is hopeless?  Yes/No

15. Do you think that most people are better off than you?  Yes/No


Form date 7/2/99
Medicare law requires that we determine if your medical services might be covered by another insurer. In order to assist us in the correct billing of these services, please answer the following questions:

Are you currently working?

No ____
Yes ____

If married, is your spouse currently working?

No ____
Yes ____

If yes, are you covered by any health insurance your spouse may have?

No ____
Yes ____

Please present all insurance cards to receptionist. Thank you.
PATIENT AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name (Last, First, Middle) ________________________________

Date of Birth: ___________________________ Phone # ___________________________

I authorize the disclosure of my protected health information between the parties below:

Department of Psychiatry

909 Wilson Rd, West Fee Hall Room B119
Address

East Lansing, MI 48824-6537
City, State, Zip Code

Phone: (517) 353-3070
Fax: (517) 884-1817
Phone/Fax Number

SEND RECORDS TO _______ REQUEST RECORDS FROM _______ (PLEASE MARK ONE)

SPECIFY THE INFORMATION TO BE DISCLOSED: Please specify date(s)

☐ All of my behavioral health information ________________________________

☐ Ongoing Communication, as needed, between the parties named above ________________________________

☐ Progress Notes / Encounters ________________________________ ☐ Treatment Summaries ________________________________

☐ Psychiatric / Psychological Assessments ________________________________

☐ Psychological Testing ________________________________ ☐ Psychotherapy Notes ________________________________

☐ Lab Reports ________________________________ ☐ Immunizations ________________________________

☐ Medications ________________________________ ☐ Consultations ________________________________

☐ Information from other healthcare providers/facilities (please specify) ________________________________

☐ Other (please specify) ________________________________

PURPOSE OF THIS DISCLOSURE:

☐ Continuing Care ☐ Insurance ☐ Legal ☐ Disability ☐ Patient Request ☐ Workers Comp

Other (please specify) ________________________________

I UNDERSTAND that if the person/entity that receives this information is not a health care provider or health plan covered by Federal privacy regulations, the information described above may not be protected from further disclosures.

I UNDERSTAND that I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment, except in very limited circumstances. I may inspect or receive a copy of the information disclosed in accordance with this Authorization.

I UNDERSTAND that I may revoke this Authorization at any time by contacting the Psychiatry Clinic except to the extent that action has been taken in reliance on this Authorization. This Authorization expires ________________________________ (or one year from the date signed).

Signature of Patient or Personal Representative (Required) ________________________________ Date (Required) ________________________________

Name of Personal Representative and Relationship to Patient (or description of authority to act on behalf of the patient) ________________________________
Thank you for choosing the Michigan State University Department of Psychiatry. We are committed to providing our patients with the best possible care and minimizing administrative costs. Please review the information below.

- Insurances vary in their coverage, and it is the **patient's responsibility** to understand his/her mental health benefits. There may be limitations and exclusions to coverage. The patient portion is set by the insurance company. **Patients are responsible for any co-payments and deductibles at the time of service. This is an insurance company policy.** Payment for professional services can be made with cash, check, VISA, MasterCard, Discover, or American Express.

- We will submit insurance claims for our patients. However, the agreement of the insurance carrier to pay for psychiatric care is a contract between **you** and the **carrier**. You should direct any questions and/or complaints regarding coverage to your insurance carrier, your employer (if in a group plan), or to your agent.

- Our staff is happy to help with insurance questions related to how a claim was filed, or regarding any additional information the carrier might need to process the claim. Specific coverage issues, however, can only be addressed by your insurance company. Please contact Customer Service at the number listed on your insurance card.

- You will be asked to review your information, including demographics and insurance information, every year. Out of date information can cause unnecessary delays in the payment of your claim.

- **No Insurance:** Payment will be due at the time of service. If you are unable to pay your balance in full, you will need to make prior arrangements with our billing office.

- **Missed Appointments/Late Cancellations:** Missed appointments (no-shows) or appointments not cancelled with 24 hours’ notice will be charged a $50 no-show fee. Charges for missed appointments are not covered by insurance. The charge will be billed directly to you, and you will be required to pay this fee prior to your next appointment. Recurrent no-shows (more than 2 within 6 months) or cancellations (more than 3 in 6 months) will result in a discharge from care.

- **Outstanding Balances:** We urge you to keep your account current. Account balances past due over 120 days will be sent to an outside agency for collection, at which time you will be discharged from care. Payment arrangements can be made with our Billing Office at (517) 884-2998.

Again, thank you for choosing us as your healthcare provider.
No-Show Policy
Quality care for our patients is our top priority. Please take a few minutes to review our No-Show policy and sign at the bottom of the form. If you have any questions, please let us know.

Definition of a No-Show Appointment
MSU Psychiatry Clinic defines a No-Show appointment as any scheduled appointment in which the patient either:
- Does not arrive to the appointment.
- Cancels with less than 24 hours' notice.
- Arrives more than 10 minutes late and is consequently unable to be seen.

Impact of a No-Show Appointment
No-show appointments have a significant negative impact on our practice and the healthcare we provide to our patients. When a patient fails to show up for a scheduled appointment it:
- Potentially jeopardizes the health of the patient.
- Is unfair (and frustrating) to other patients who would have taken the appointment slot.
- Is disrespectful of the provider’s time.

How to Avoid Getting a No-Show
1. **Confirm** your appointment
2. **Arrive** 5-10 minutes early
3. **Give 24 hours’** notice to cancel appointment

1. Appointment Confirmation
MSU Psychiatry Clinic will attempt to contact you 2-3 business days before your scheduled appointment to confirm your visit. If our automated system is unable to confirm with you over the phone, we will leave a message with your appointment date and time.

2. Always Arrive 5-10 Minutes Early
When you schedule an office visit with us, we expect you to arrive at our clinic 5-10 minutes prior to your scheduled visit. This allows time for you and our staff to address any insurance or billing questions, and to complete any necessary paperwork before the scheduled visit.

3. Give 24 Hours’ Notice if You Need to Cancel
When you need to cancel or reschedule an appointment, we expect you to contact our office no later than 24 hours before the scheduled visit. This allows us a reasonable amount of time to determine the most appropriate way to reschedule your care, as well as giving us the opportunity to rebook the vacant appointment slot with another patient. If it is less than 24 hours before your appointment and something comes up, please give us the courtesy of a phone call at 517-353-3070.

Consequences of No-Show Appointments
1. You will be charged a $50 no-show fee for each missed appointment.
2. If you miss 3 or more appointments within a year, you will be discharged from the clinic.
3. If you are discharged from the clinic, your remaining scheduled appointments will be cancelled.
4. Only emergency medical treatment will be offered within the first 30 days of discharge.

I have read and understand the MSU Psychiatry Clinic “No Show” policy as described above.

Patient/Guardian Signature

Date