Guadalupe Psychiatric and Mental Health Services, PC

Patient Information: Date:

First Name: Middle Name: Last Name:

What do you prefer to be called when we call to confirm appts.?

Date of Birth:

Gender: Male ○ Female ○ Social Security Number:

Street Address:

City: State: Zip:

Cell Phone # Would you like a text reminder about next appt? yes ☐ no ☐

Home Phone #: Do you want to leave a message about your appts? yes ☐ no ☐

Email: Would you like an email reminder about next appt? yes ☐ no ☐
Would you like to sign up for your Patient Portal? yes ☐ no ☐

Marital Status: Married Widowed Divorced Single Domestic Partner

Pharmacy Phone #

Occupation: Employer: Phone #

Please list trusted people that are allowed to ask questions in your care. Examples: Anything involving appts and what type of Doctor/Office we are, medication/Script Picks up, Medication questions and talking with providers about your care. Please list their name, phone number and relationship to you.

Name	Relation	Phone #

Emergency Contact: Relation: Phone #:

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Medical History

Are you feeling suicidal right now? Yes ○ No ○

What is the reason for your visit?

Have you received psychiatric treatment in the past? If yes please list providers, hospitalizations and prior-suicidal, homicidal attempts and prior psychiatric diagnosis.

Have you ever been hospitalized in a psychiatric facility? ☐No ☐Yes If so, where and when?

Were any medications ever prescribed to you by a psychiatrist or other providers for psychiatric illness or symptoms?☐No ☐Yes, if so what was prescribed and for how long? Why did you stop taking your medication(s) if you did?

Current Psychiatric Medication(s), Dose/Frequency:

PAST Psychiatric Medication(s), include dose and duration of time you took them:
Other Medications you take:

Allergies (Medication/Food): What occurs when you have a reaction?:

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Life Style:

- Smoke
  Cigarettes/Day
  ____
  For How long:
  ____
- Coffee/Caffeine
- Physical/Emotional Abuse
- Sexual Abuse
- Domestic Abuse

On-going Medical Problems:

- Anemia
- Asthma/COPD
- Arthritis
- Bleeding Disorder
- Cancer
- CVA/TIA (strokes)
- Diabetes
- Depression/Anxiety
- Epilepsy
- Heart Disease
- Headaches
- HIV
- Hypertension
- Kidney/Liver Disease
- Nerve Disease
- Seizures
- Substance Abuse
- TB
- Thyroid
- Sleep problems
- Other_______________

Major Events/Hospitalizations and Surgeries:

Have you ever tried drugs and when was date of last use?

Marijuana Yes ○ No ○

Cocaine Yes ○ No ○

Methamphetamines Yes ○ No ○

Heroine Yes ○ No ○

Others:

How much alcohol are you currently using weekly?

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Payment Responsibility

GPMHS is committed to providing you with high quality psychiatric care in the most cost effective manner possible. In order to accomplish this, we depend upon your prompt payment for the services we provide. By my signature below, I understand that I am responsible for full payment of services provided by Guadalupe Psychiatric and Mental Health Services, and any of it providers; either through my insurance policy or personal payment. I understand that I may be billed by Guadalupe Psychiatric and mental Health Services has my authorization to process my insurance claims and to be paid directly by my insurance. In the event that my insurance denies payment for the services provided for any reason. I agree to pay in full for services provided.

Copays, when applicable, must be paid at the time of the appointment.
Payments for all services must be paid or arranged for at time of visit.

Insurance cards must be presented at every visit. Correct and current insurance information is required for prompt and proper payment of claims.

Patients are responsible to know what their insurance will cover. Patients will be liable for all non-covered services.

<u>A prior-authorization is not a guarantee of services covered.</u> Patients will be liable for any service done that insurance will not pay for.

Payment (full or partial) of outstanding bills is required before subsequent appointment can be scheduled.

Patient Signature____ Date_________________________

Authorized Patient Representative__________________________Date_________________________

Does this visit pertain to Worker's Compensation, FMLA, or Disability? Yes ○ No ○

Are you covered by insurance? Yes ○ No ○

Primary Insurance Company:
Policy/ID #: Group #: Phone #:
Policy Holder's Name: Relationship: DOB:
Policy Holder's Address:
Policy Holders Employer:

Secondary Insurance Company:
Policy/ID #: Group #: Phone #:
Policy Holder's Name: Relationship: DOB:
Policy Holder's Address:
Policy Holders Employer:

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Notice of privacy Practice Acknowledgment

By my signature I acknowledge that I have reviewed and received a copy of the Notice of Privacy Practices for Guadalupe Psychiatric and Mental Health Services.

Patient Signature____ Date__________________________

Authorized Patient Representative___________________________Date__________________________

Consent for Diagnosis and Treatment

The undersigned does herby request and gives consent to Dr. Yvonne Hall MD and Jimmy Calzado NP, as well as other providers of Guadalupe psychiatric and mental health services to diagnose, treat, and perform procedures deemed necessary for the interest and treatment of:

Patient Signature____ Date__________________________

Authorized Patient Representative___________________________Date__________________________

Policy Regarding Disability paperwork, copy of records, Letters in General that are not clinically related

As a courtesy to our patients we will assist with filling out disability paperwork, and needed letters for work, probation and other not clinically related matters. This is not our first priority however, and even though we will make every effort to be timely we have a minimum of 3 days to 2 weeks to complete this type of request.
We do not fax this type of paper-work directly; you must pick it up and fax it yourself.
If your insurance requires for us to fax the paperwork directly there is a faxing fee of $1 per page. You will receive confirmation of us sending the fax. If it requires to be refaxed the $1 fee will re-apply as we are not responsible for lost faxes.
We appreciate your understanding in this issue, as it permits us to focus our attention on your health which is our first priority.
Please sign that you have read and understand this policy.

Patient Signature____ Date__________________________

Authorized Patient Representative___________________________Date__________________________

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Practice Information

Physicians

Yvonne D. Hall MD
Jimmy Calzado NP
Jerome Sather
Sandra Crum

Front Office

Shannon Holiday
Deborah Aguilar

Dear Patient:

I would like to welcome you to Guadalupe Psychiatric and Mental Health Services (GPMHS); you will be seen by board certified in Psychiatrist who specializes in Geriatric Psychiatry or a board certified Psychiatrist Nurse Practioner. I will provide you with professional, timely and comprehensive psychiatric and mental health services, to help you improve your quality of life.

- Office hours are: Monday's to Friday 7am to 4pm. We take lunch at 12pm.
- To schedule or change an appointment call (505)515-3982, and leave a voice mail. Please give us a 24 hr. notice of your changed appointment or cancelled appt. It allows us to get in other patients that need to be seen by a Physician sooner. If you cancel less than 24 hrs. or do a 'no call no show', we will bill you $35. And insurance don't pay for those.
- For non-urgent call (505)515-3982 Ext. 0 and leave a voice mail. Your call will be returned between 48 and 72 hours.
- For urgent issues, after office hours, please call (505)459-6101, your call will be returned within 6 hours.
- For life threatening emergencies please call 911.
- Medical records are web based through Practice Fusion a HIPPA compliant internet medical record provider.
- Prescription refills- Please have your pharmacy request an e-script refill or fax a prescription refill request to (505)792-6060. Please allow 72 hrs for the refill to filled.
- Hospitalization-If you are in need of hospitalization, we will help coordinate your admission to a hospital covered by your insurance plan.

By my signature below, I acknowledge that I have read and understand the practice information and agree and accept those practices.

Patient Signature____ Date__________________________

Authorized Patient Representative___________________________Date__________________________