LOTT BEHAVIORAL HEALTH, LTD.

MEDICAL HISTORY FORM

Date: _____/_____/_____

Name: _____ Birthday:_____/_____ /_____
Last First M.I.

Age: _____ Gender: ☐ F ☐ M ☐ Other _____

Describe why you made this appointment (recent symptoms, treatment issues, etc.):

MEDICAL HISTORY

Do you now or have you ever had:

☐ Diabetes	☐ Heart murmur	☐ Crohn's disease
☐ High blood pressure	☐ Pneumonia	☐ Colitis
☐ High cholesterol	☐ Pulmonary embolism	☐ Anemia
☐ Hypothyroidism	☐ Asthma	☐ Jaundice
☐ Goiter	☐ Emphysema	☐ Hepatitis
☐ Cancer (type) _____	☐ Stroke	☐ Stomach or peptic ulcer
☐ Leukemia	☐ Epilepsy (seizures)	☐ Rheumatic fever
☐ Psoriasis	☐ Cataracts	☐ Tuberculosis
☐ Angina	☐ Kidney disease	☐ HIV/AIDS
☐ Heart Problems	☐ Kidney stones	
☐ Arrhythmia		

Other medical conditions (please list):

_____

_____

Patient Signature _____ Physician Initials _____

PERSONAL HISTORY

Were there problems with your birth? (please specify)

Where were you born & raised?

What is your highest level of education?

☐ High school ☐ Some college ☐ College graduate ☐ Advanced degree

Marital Status?

☐ Never Married ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Partnered/Significant other

What is your current or past occupation?

Are you currently working?

☐ Yes ☐ No Hours/week _____ If not, are you ☐ Retired ☐ Disabled ☐ Sick Leave?

Have you ever had legal problems? (please specify)

Religion:

FAMILY HISTORY

	Health & Psychiatric	Age(s) at death	Cause
Father			
Mother			
Siblings			
Children			

EXTENDED FAMILY PSYCHIATRIC PROBLEMS PAST & PRESENT

Maternal Relatives:

Paternal Relatives:

Patient Signature _____ Physician Initials _____

SYSTEMS REVIEW

In the past month, have you had any of the following problems?

GENERAL
☐ Recent weight gain
How much _____
Over _____ month
☐ Recent weight loss
How much _____
Over _____ months
☐ Fatigue
☐ Weakness
☐ Fever
☐ Night sweats

MUSCLES/JOINTS/BONES
☐ Numbness
☐ Joint pain
☐ Muscle weakness
☐ Joint Swelling
Where?

EARS
☐ Ringing in ears
☐ Loss of hearing

EYES
☐ Pain
☐ Redness
☐ Loss of vision
☐ Double or blurred vision
☐ Dryness

THROAT
☐ Frequent sore throats
☐ Hoarseness
☐ Difficulty in swallowing
☐ Pain in jaw

OTHER PROBLEMS:

HEART AND LUNGS
☐ Chest pain
☐ Palpitations
☐ Shortness of breath
☐ Fainting
☐ Swollen legs or feet
☐ Cough

NERVOUS SYSTEM
☐ Headaches
☐ Dizziness
☐ Fainting or loss of consciousness
☐ Numbness or tingling
☐ Memory Loss

GASTROINTESTINAL
☐ Nausea
☐ Heartburn
☐ Stomach pain
☐ Vomiting
☐ Yellow jaundice
☐ Increasing constipation
☐ Persistent diarrhea
☐ Blood in stools
☐ Black stools

SKIN
☐ Redness
☐ Rash
☐ Nodules/bumps
☐ Hair loss
☐ Color changes of hands or feet

BLOOD
☐ Anemia
☐ Clots

WOMEN ONLY
☐ Abnormal pap smear
☐ Irregular periods
☐ Bleeding between periods
☐ PMS

KIDNEY/URINE/BLADDER
☐ Frequent or painful urination
☐ Blood in urine

PSYCHIATRIC
☐ Depression
☐ Excessive worries
☐ Difficulty falling asleep
☐ Difficulty staying asleep
☐ Difficulties with sexual arousal
☐ Poor appetite
☐ Food cravings
☐ Frequent crying
☐ Sensitivity
☐ Thoughts of suicide / attempts
☐ Stress
☐ Irritability
☐ Poor concentration
☐ Racing thoughts
☐ Hallucinations
☐ Rapid speech
☐ Guilty thoughts
☐ Paranoia
☐ Mood swings
☐ Anxiety
☐ Risky behavior

WOMENS REPRODUCTIVE HISTORY

Age of first period:
Number of pregnancies:
Number of miscarriages:
Number of abortions:
Have you reached menopause? Y / N
At what age?
Do you have regular periods? Y / N

Patient Signature _____ Physician Initials _____

SUBSTANCE MISUSE					
DRUG CATEGORY (Circle each substance used)	Age when you first used this:	How much & how often did you use this?	How many years did you use this?	When did you last use this?	Do you currently use this?
ALCOHOL					Yes ☐ No ☐
CANNABIS: Marijuana, hashish, hash oil, THC					Yes ☐ No ☐
STIMULANTS: Cocaine, crack					Yes ☐ No ☐
STIMULANTS: Methamphetamine—speed, ice, crank					Yes ☐ No ☐
AMPHETAMINES/OTHER STIMULANTS Ritalin, Adderall, Dexedrine, etc.					Yes ☐ No ☐
BENZODIAZEPINES/TRANQUILIZERS Valium, Librium, Halcion, Xanax, Diazepam, etc.					Yes ☐ No ☐
SEDATIVES/HYPNOTICS/BARBITURATES Amytal, Seconal, Dalmane, Quaalude, Phenobarbital					Yes ☐ No ☐
HEROIN					Yes ☐ No ☐
STREET OR ILLICIT METHADONE					Yes ☐ No ☐
OTHER OPIOIDS Tylenol #2 & #3, Vicodin, Norco, Percocet, Opium, Morphine, Fentanyl, Dilaudid, etc.					Yes ☐ No ☐
HALLUCINOGENS: LSD, MDA, DAT, mescaline, peyote, mushrooms, ecstasy (MDMA), nitrous oxide, etc.					Yes ☐ No ☐
INHALANTS: Glue, gasoline, aerosols, paint thinner, poppers, air duster, etc.					Yes ☐ No ☐
TOBACCO, NICOTINE, VAPING, AND OTHERS: Specify _____ _____ _____					Yes ☐ No ☐

Patient Signature _____ Physician Initials _____

LOTT BEHAVIORAL HEALTH, LTD.

PATIENT INFORMATION

Patient Name: _____
First Name Last Name M.I.

How you wish to be addressed: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home: _____ Work: _____ Cell: _____

Where may we leave a message? ☐ Home ☐ Work ☐ Cell

Date of Birth: _____ Age: _____ Social Security #: _____

Gender: ☐ Male ☐ Female ☐ Other **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Who referred you to us? (Name & Phone) _____

Primary Insurance Company:

_____

Subscriber Name: _____ _____
First Name Last Name Birth Date

Address & Phone: _____

Insurance ID: _____ Group Number: _____

Secondary Insurance Company:

_____

Patient Name: _____ _____
First Name Last Name Birth Date

Address & Phone: _____

Insurance ID: _____ Group Number: _____

I hereby authorize Lott Behavioral Health, Ltd. to furnish my insurance company all information that may be requested concerning claim processing. I am financially responsible for charges not covered by my insurance company. I hereby assign to Lott Behavioral Health, Ltd. all monies to which I am entitled for expenses relative to the services received. I understand that if I am self-pay or have out-of-network insurance that payment is due in full at the time of service and my insurance company will need to reimburse me personally.

_____ _____
Patient Signature Date

_____ _____
Parent or Legal Guardian Signature if applicable Date

LOTT BEHAVIORAL HEALTH, LTD.

Appointment Reminders

The office currently uses an automated system to send some appointment reminders. These reminders, whether through the automated system or otherwise, are given as a courtesy and do not affect the cancellation policy. The system currently offers reminders by email as well as one of the following 2 additional methods: texting or automated call reminders, but these options could change in the future. The current system requires email in order to work.

_____

Patient Name

Methods of contact for appointment reminders (email and either text OR voice):

☐ **Voice message** OR ☐ **Text message**

_____

Phone Number

Email → _____

Email Address

Additional Information:

Emergency Contact Name: _____

Relationship: _____

Emergency Contact Phone Number: _____

I consent to receive emails, calls, or text messages from the practice at my phones and any number forwarded or transferred to/from that number or emails to receive communication as stated above. I understand that this request to receive emails, calls, and text messages will apply to all future appointment reminders unless I request a change in writing. The practice does not charge for this service, but standard data rates may apply as provided in my plans. I understand that although the systems use secure communication, no electronic communication can be completely secure from all unforeseen circumstances.

Signature:_____ Date :_____

LOTT BEHAVIORAL HEALTH, LTD.

MEDICATION LIST

Patient Name: _____ Date _____

What medications are you currently taking? (Please list below)

① _____
Name of Medication Dose Qty / Times Per Day Prescribing Doctor

② _____
Name of Medication Dose Qty / Times Per Day Prescribing Doctor

③ _____
Name of Medication Dose Qty / Times Per Day Prescribing Doctor

④ _____
Name of Medication Dose Qty / Times Per Day Prescribing Doctor

⑤ _____
Name of Medication Dose Qty / Times Per Day Prescribing Doctor

⑥ _____
Name of Medication Dose Qty / Times Per Day Prescribing Doctor

⑦ _____
Name of Medication Dose Qty / Times Per Day Prescribing Doctor

⑧ _____
Name of Medication Dose Qty / Times Per Day Prescribing Doctor

Do you have any allergies to any medications? YES NO (If YES please list)

_____

_____

_____

Preferred Pharmacy Name: _____

Street: _____

City & State: _____

LOTT BEHAVIORAL HEALTH, LTD.

OFFICE POLICIES

Thank you for choosing us as your health care provider. The following is a statement of our Office Policies.

Usual and Customary Rates:
The office currently utilizes usual and customary fees for this area. An insurance contract is an agreement between you, the patient, and your insurance carrier; therefore, you are responsible for payment regardless of any insurance company's determination of rates. In the event that an authorization from your insurance company is not obtained, you will still be responsible for payment of services rendered. All patients may receive an invoice and other documentation to provide any information necessary to assist in your own effort to obtain insurance reimbursement. Please be aware there may be additional charges for phone calls, refills between visits, completing forms, and other services.

In-Network Insurance Coverage:
Patients who are members of BCBS PPO who have co-pay insurance policy will be required to pay a co-payment, which your insurance company requires us to collect at the time of service. With any deductible plan, your visit will be billed to your insurance carrier and any remaining balance will be the patient's responsibility.

Self-Pay and Out-of-Network Insurance Policy:
For all patients who are self-pay or have out-of-network insurance, payment for services rendered are due in full at the time of service. Patients with out-of-network insurance benefits can receive reimbursement directly from their insurance company as this office is not currently contracting with any companies other than BCBS PPO.

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Patient Accounts:
Patient accounts with no payment activity or those with previous payments arrangements that are not being adhered to, will be considered **past due** after **30 days** and your credit card on file will be charged around the 21st of each month. Your account may be referred to an outside agency for collection, and any costs associated with this action will be the responsibility of the patient. Accounts with balances **past 90 days** will be subject to a finance charge of 1.5% per month. Patients with delinquent bills may also be dismissed from the practice.

The office currently accepts payments by cash, credit cards or by check. However, if an account is paid for by check or credit card and the check is returned or the credit card charge is disputed **inappropriately** the account will be subject to a $25 returned item **fee** plus any additional fees incurred by either banking institution.

_____ _____

Patient Signature Date

_____ _____

Parent Signature if patient is less than 18 years of age or Legal Guardian Signature if applicable. Date

LOTT BEHAVIORAL HEALTH, LTD.

CONTINUATION OF OFFICE POLICIES

Confidentiality:
Mental Health law dictates that we can neither confirm nor deny that a patient is being seen or has been seen at our practice without **written** authorization from the patient, which includes any and all family members unless the patient is less than 12 years of age. ***Please be advised that questions regarding billing matters can be discussed with the patient, guardian or insurance policy holder without written authorization.**

Phone Calls
Phone calls will typically be returned only when the office is open. These times and/or days are subject to change, especially if they fall on a holiday. When your provider is out of the office, the answering service will be available for emergencies, and the office phone will be available again on the following regular hours business day. Phone calls with your provider, whether or not they are placed during business hours, may also be billed to the patient (not their insurance company) at the provider's discretion.

If your situation is an emergency and you need immediate attention, please call 911 or go to your closest emergency room. Dr. Lott can also be paged by the answering service for matters that are urgent and require immediate attention; however, calls paged to Dr. Lott may be subject to a **$50.00 fee** for the first ten minutes of a call and **$25.00** for every ten minutes thereafter. ***Charges for these Phone Call Fees are not billed to insurance and will be applied to the credit card on file.**

Medication Refills
The office requires **at least 2 business days' notice** from the patient for refills to be processed. Refills will only be accommodated when the provider is in the office. Controlled Substance medications are monitored by the DEA and for regulatory reasons, controlled medications will only be mailed to the patient by **Certified Mail.** This is a fee that must be paid by the patient before the prescription is mailed out. Prescriptions outside of an appointment as well as misplaced prescriptions will not be issued to patients on a regular basis and may be subject to an additional $30 prescription fee. Please contact the office regarding these events if they occur.

_____ _____
Patient Signature Date

_____ _____
Parent Signature if patient is less than 18 years of age or Legal Guardian Signature if applicable. Date

LOTT BEHAVIORAL HEALTH, LTD.

FAILED APPOINTMENT / LATE CANCELLATION POLICY

Regular appointments are an important part of your treatment. Scheduled appointments must be cancelled by noon on the previous business day or you will be charged a Late Cancellation Fee. For appointments on Mondays or days after a holiday, this means that the cancellation must be made before the appointment time on the most recent regular business day (i.e. Monday appointments typically must be cancelled before the appointment time on the preceding Friday).

Arrivals of more than 10 minutes late may need to be rescheduled and will also be charged a Late Cancellation Fee. Should you fail to show up for an appointment you will be charged a Failed Appointment Fee. Your credit card on file at the office will be charged for any of these fees; if the card is declined the fee must be paid prior to your next scheduled visit. These charges are not billed to your insurance company. Fees are currently $100 for therapy appointments or medication treatment sessions over 1 hour, and $75 for other visits, but these are subject to change.

I have read and understand the above stated Failed Appointment / Late Cancellation Policy.

_____ _____

Patient Signature Date

_____ _____

Parent Signature if patient is less than 18 years of age or Legal Guardian Signature if applicable. Date

LOTT BEHAVIORAL HEALTH, LTD.

PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Patient Printed Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____

If Applicable:

Parent/Guardian Printed Name: _____

***Parent only if patient is less than 18 years of age**

Parent/Guardian Signature: _____ Date: _____

LOTT BEHAVIORAL HEALTH, LTD.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

_____ _____
Patient Name Date of Birth

I hereby freely and voluntarily authorize Lott Behavioral Health, Ltd. to receive or disclose information from/to:

Provider/Facility Name: _____

Phone: _____ Fax: _____

Address: _____
Street City State Zip

The purpose of this disclosure is: _____

By checking the spaces below, I specifically authorize the release or disclosure of the following information and/or records, if such information and/or records exist:

____ Entire Record
____ Progress Notes
____ Laboratory Reports
____ Medication Record
____ Discharge Summary
____ Educational Evaluation
____ Neuropsychological Test Report
____ Psychiatric Evaluation/Assessment
____ Psychological Test Report
____ Other (Specify) _____
____ Physician Orders
____ Billing Information
____ Treatment Plan

Approximate Treatment Dates Between _____ and _____

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment. I understand that I may revoke this authorization at any time, provided that I do so in writing and submit it to Lott Behavioral Health, Ltd. The revocation will need to be signed by me and be witnessed by a person who can attest to my identity. Any revocation will take effect when Lott Behavioral Health, Ltd. receives the revocation, except to the extent that Lott Behavioral Health, Ltd. has already relied on the authorization. I understand I have the right to inspect or copy any information to be used or disclosed under this authorization. I understand that no person or agency to whom any information is disclosed may re-disclose the information unless I specifically consent to re-disclosure.

This authorization will terminate on _____ or if no date is marked, it will automatically terminate five years from the date it was signed.

Patient Signature: _____ Date: _____

Parent/L.G. Signature: _____ Date: _____

Witness Signature: _____ Date: _____