Alkire Creek Psychiatry

Jorden Weiss, D.O.

279 N. State Street, Ste. 102
Westerville, OH 43081
Office: 614-818-0101/Fax: 614-818-0103

Today's Date: _____

Patient Name: _____

Date of Birth: _____SSN: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____

Mobile: _____ e-mail address: _____

Where can we leave a message? _____

Sex: M F Employed: Y N Student: Y N Marital Status: M S D W O

Employer: _____

Emergency contact and number: _____

****

Responsible Party

( ) Same as above

Relationship to patient: _____

Name: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____

Mobile: _____ e-mail address: _____

Employer: _____

****

Insurance (primary only)

Insured's Name: _____

SSN: _____ Relationship to patient: _____

ID number: _____ DOB: _____

Address: _____

Phone number: _____ Employer: _____

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Treatment Consent/Authorization for Disclosure

Consent to Treatment

I, the undersigned, do voluntarily consent and authorize outpatient treatment as judged to be necessary by my clinician. Such treatment may include diagnosis/assessment procedures, psychotherapy and pharmacotherapy. I understand that this consent authorizes the use of standard and customary community standards, and I have been advised of the potential risks and benefits associated with treatment. I understand the practice of medicine, psychiatry and other mental health disciplines is not an exact science and I acknowledge that no guarantees have been made to me concerning my care. Because psychotherapy is a cooperative effort between patient and therapist, I will work with my therapist in a cooperative manner to resolve my difficulties. If I refuse the treatment that is suggested for me or discontinue treatment, I will not hold Jorden Weiss, D.O., Inc. or any individual responsible for any consequences resulting from my decision beyond that time. I understand that state and local laws require that my psychiatrist/therapist report all cases in which there exists a specific potential harm to others or in cases of reported or suspected physical, sexual and/or neglect of children which are required by Ohio law.

Authorize for Disclosure of Information

The undersigned hereby authorizes Jorden Weiss, D.O., Inc. and its staff to release or disclose information in the medical, business or clinical record of the patient of the following:

- Any private or public entity with which a claim is being filed for a (all or part) of the patient's charges, including any insurance carrier or compensation carrier or any of the respective agents, representatives, and claims processing personnel;
- Any attorney, collection agency or other persons or entities engaged in the collection of responsible party to Jorden Weiss, D.O., Inc.;
- Any other healthcare professional staff providing needed care;
- Any person, corporation, public or private agency to the extent necessary for Jorden Weiss, D.O., Inc. to obtain and/or maintain licensure, federal and/or state reimbursement for the provisions of health care services or clarification;
- Any public or private utilization review organization needing information by telephone or writing to certify the medical necessity or appropriateness of treatment services under review;
- Any Jorden Weiss, D.O., Inc. employee or provider requiring information including patient identity and address in order to provide care and/or maintain the medical records;
- For any release beyond the scope of this consent, the patient will be asked to sign a Release of Information Form.

The information release may include diagnosis and treatment including, but not limited to mental and physical condition, drug/alcohol and other information requested to determine coverage, medical necessity and other benefits determination.

This authorization may be revoked at any time except to the extent those actions have already been taken. To cancel this authorization, the patient and/or responsible party realizes that they must do so in writing and send it to Jorden Weiss, D.O., Inc.

_____ _____

Signature of Patient **Date**

_____ _____

Spouse/Parent/Guardian **Date**

Updated 09/2012

Alkire Creek Psychiatry

Jorden Weiss, D.O.

Referral Source/Primary Care Physician Notification

The undersigned hereby authorizes Jorden Weiss, D.O., Inc. to notify the referral source of the patient's contact with Jorden Weiss, D.O., Inc. The undersigned also authorizes Jorden Weiss, D.O., Inc. to notify the primary care physician listed below to share diagnosis and treatment plan to insure integrated treatment.

Put your initials on the line for "yes" or "no"

Initial: _____YES _____NO Referral Source (Name) _____

Address_____ City, State, Zip_____

Initial: _____ YES _____NO Primary Care Physician_____

Address: _____ City, State, Zip_____

Jorden Brent Weiss, D.O. Inc.

Policies & Procedures*:

Self-Pay Fees & Balances: All are due in full at time of check-in, or your appointment may need to be rescheduled.

Form Completion: Requested form completions (Letters, FMLA, etc.), will be charged based on clinician time involved with a minimum $25.00 paperwork fee assessed. Please allow **7-10** business days. Dr. Weiss does not complete disability paperwork or perform disability assessments.

Record Transfers: There is a $25.00 fee to transfer patient records to other providers, due from the patient before the records will be sent. Psychiatric records cannot be released to patients but can be forwarded to other physicians.

Prior Authorizations: Patients are responsible for contacting their insurance companies when their medication requires a prior authorization. Your insurance company will then fax a form to our office for the doctor to complete and fax back. A fee of $25.00 will be assessed to cover this timely process.

After Hour/Emergency Fees: Appointments required after normal office hours (Mon–Thurs after 6 pm) will be assessed an emergency fee of an additional $150.00, only scheduled with Dr.'s approval.

Phone consultations: A fee for extended telephone conversations beyond 10 minutes will be assessed at the doctor's hourly rate of $250.00 per hour.

On Call Physician: Dr. Weiss is available for **urgent problems only from 6:00 PM- 9:00 PM weekdays and 10:00 AM-1:00 PM weekends and holidays.** For non-emergency questions, please contact our office the next business day. **This service is not for prescription refills.**
****** If you are experiencing acute distress, self-harm or suicidal thoughts, please call 911 or go to your nearest emergency room or contact Netcare Access at:***
(614) 276-2273 (CARE) ***

Print name: _____ **Signature**: _____

Witness: _____ **Date**: _____

**Policies and procedures are subject to change*

_____Patient received copy of policy/procedures (please initial)

Updated 09/2012

Jorden Brent Weiss, D.O. Inc.

Appointments/Cancellations:

- A ***48-hour notice*** must be given when cancelling your appointment in order to avoid a charge. This will allow us to reach someone on our waiting list and offer them the appointment time.

- Failure to give 48-hour notice for cancellations will result in a charge of **50%** of the 15-30 minute medication check visit or **full fee** charge for 1 hour psychotherapy or therapy/medication management appointments; ***this is due ON OR BEFORE your next appointment.***

- For new patient evaluations, we ask that you give **48 hour** notice for cancelling. If you do not provide 48 hour notice we will not reschedule your appointment.

- **Late Arrivals** may lose appointment times and will either need to reschedule or be seen after other patients. Punctual arrivals will have priority.

- **Termination of Service:** Multiple late cancellations, no-shows and other forms of non-compliance with treatment may result in termination of services.

- **Reminder calls:** As a courtesy, we offer reminder calls about your upcoming appointment, typically 2 business days in advance. Due to unforeseen circumstances, we are not always able to do so, but please remember that you are ultimately responsible for your scheduled appointments.

Professional Services

The fee for phone conferences, extended sessions, preparation of letters and treatment summaries, reading and responding to correspondence (including past records and email), site visits, travel time, and consultation with other professionals is $250.00 per hour. Payment is due at the time services are rendered.

Forensic Services: Fees apply to time spent and attorney's fees in connection with a subpoena or other record requests that your doctor might receive involving your (or your child's) treatment. This includes the cost of seeking to block a release of information to the court, should you choose this course. Fees will also apply to legal testimony, preparation time, travel time, and time spent waiting to testify. The fee for these services is $400.00 per hour.

Print name: _____ **Signature**: _____

Witness: _____ **Date**: _____

**Policies and procedures are subject to change*

_____Patient received copy of policy/procedures (please initial)

Updated 09/2012

Jorden Brent Weiss, D.O. Inc.

Prescription Drug Policy*:

A comprehensive psychiatric evaluation with Dr. Weiss will be required in order to receive a prescription for medication. Patients will be scheduled for follow-up medication management sessions to assure the best continuity of care. When you attend your appointment, you will always be given enough medication until your next scheduled appointment. In order to provide the best ongoing care, we ask that our patients be aware of the following:

- **Any lost or stolen schedule II or IV prescriptions will not be replaced or re-written.**
- If you miss or cancel an appointment, it is at the physician's discretion to write a prescription for enough medication to last only until the next appointment.
- *No medication will be called in to the pharmacy; all prescriptions must be picked up by the patient or family member.*
- *A **$20.00 fee** will be assessed for each* prescription written outside of an appointment and must be paid for at the time of pick up. Please allow 48 hours to prepare your prescription.
- **Please note:** We do not mail prescriptions to patients or release prescriptions to 3rd party courier/ delivery services.
- Medication changes will only be addressed during scheduled appointment times. If you are having side effects or urgent issues with the medication you are taking, this can be addressed over the phone with our support staff. After hours issues will need to be directed to urgent care or emergency facilities.
- All requests for 90-day prescriptions will only be written during scheduled appointments. Dr. Weiss is unable to provide 90 day prescriptions for controlled substances such as stimulants and benzodiazepines.
- If it has been six months or longer since your last appointment, you will need to be seen for a re-assessment before medication will be prescribed.
- You must call personally for any appointment or medication request; *we will not accept faxes from your local or mail order pharmacy, nor do we fax prescriptions to pharmacies.*
- Prescriptions will not be refilled on weekends, holidays or after 12:00 pm on Friday.

In addition, when you leave a message on our voicemail, please leave a phone number where you can be easily reached during office hours. Due to the high number of patient messages left every day, it is not possible for us to repeatedly return phone calls.

Print name: _____ **Signature**: _____

Witness: _____ **Date**: _____

**Policies and procedures are subject to change*

_____Patient received copy of medication policy (please initial)

Updated 09/2012

JORDEN WEISS, D.O. INC.

279 N. State Street, Suite 102
Westerville, OH 43081

CHILD/ADOLESCENT
Outpatient Biopsychology Database

Today's Date: _____

Patient's Name: _____ DOB: _____ Age: _____

Sex: □ Male □ Female Race: _____

Referred by: _____ Phone: _____

Custodial Parent or Guardian (if applicable): _____

Name of Person Completing the Form: _____ Relationship: _____

Parent of Guardian Information
(If parent address info is same, record one and write "same" for the other)

MOTHER

Name: _____

Address: _____

_____

Phone: _____ Cell: _____

Employer: _____

FATHER

Name: _____

Address: _____

_____

Phone: _____ Cell: _____

Employer: _____

Guardian/Other:

Name: _____ Relationship to patient: _____

Address: _____

Phone: _____

School Information:

Name of School: _____ Grade Level: _____

School District: _____

Special Services: (check all that apply) □NONE □SBH □LD □DH □Home School

□Other: _____

People NOW Living in Patient's Home

Name	Relationship to Patient	Age	Sex

Family Members Living AWAY from Patient's Home

Name	Relationship to Patient	Age	Sex

Please answer the following questions about your child/adolescent:

What are your child's most serious problems?

1. _____
2. _____
3. _____

What have you tried to solve these problems?

1. _____
2. _____
3. _____

Check any changes or stressors that might have brought on or added to the above problems:

□New brother/sister	□Family financial pressures	□Traumatic experience
□Job changes	□School pressures	□Moves
□School changes	□Divorce/separation	□Activity/sports pressure
□Marriage/ new relationship	□Loss/change of friend's	□Family medical problems
□Alcohol use	□Drug use	□Family mental illness
□Deaths	□Health problems	□other: _____

Past or Current Mental Health Services or Substance Abuse Treatment

Provider	**Dates**	**Type of Treatment**

□**Children's Services:**

Has there been contact with Children's Service? □No □Yes

If yes, when? _____ County: _____

Caseworker: _____

Court and/or Police Contacts:

Has there been contact with the Courts or the Police? No Yes

If yes, when? _____ County: _____

Probation Officer: _____

Developmental Information

(Circle or check the appropriate response)

Adoption: Is this child adopted? No Yes Age at adoption? _____

Pregnancy: Was the pregnancy unexpected? No Yes

Mother's age at delivery: _____

Problems with pregnancy: _____

Medicines taken during pregnancy other than vitamins and iron: _____

_____

Did mother drink and/or use during pregnancy? No Yes Describe: _____

Was the child born more than 3 weeks before or after the expected date? No Yes
Were there any problems with delivery? No Yes
Was the birth by "C" section? No Yes
Were there any problems with child, noticed at birth? No Yes Describe: _____

Ages 00 to 12 months (During the first year of the child)

- Usually fussy, very hard to soothe
- Hard to cuddle (stiff or floppy)
- Slow to smile or sit or crawl
- Unusually quiet, not responding much to attention
- Bothered with feeding problems
- Not interested in looking at people

Ages 1 to 5 years during this time period was the child:

- Late walking
- Hard to understand
- Difficult to toilet train
- Late talking
- Said to be slow delayed or retarded
- Hard to control in public places
- Needing much supervision to prevent dangers behavior
- Very demanding, wanting things right away
- Often fighting, biting, scratching over little frustrations
- Having severe or frequent tantrums
- Unable to get along well in pre-school or Kindergarten
- Having trouble sharing or taking turns
- Showing unusual behaviors, body movements, tics, or nervous habits
- Setting fires
- Hard to leave with baby-sitter
- Bothered by unusual fears
- Lack of imaginative play
- Unusually upset by changes or new situations
- Hard to control in public places
- Having frequent sleep problems

Family Mental Health History

(Check the item if there is a family member with the problem, Next to the problem indicate the relationship to the child, i.e. parent, brother, sister, aunt, uncle, grandmother or grandfather, etc.)

	Relationship		Relationship
□Alcoholism	_____		
□Autism	_____	□Depression	_____
□Heavy drinking	_____	□Suicide Attempt	_____
□Other Addictive Disorders	_____	□Intentional self-harm	_____
□Drug Abuse	_____	□Suicide	_____
□In trouble with the law	_____	□Tics or Tourette's	_____
□Attention problems "ADD"	_____	□Hyperactivity	_____
□Learning problems	_____	□Severe Anxiety	_____
□Dyslexia	_____	□Panic Attacks	_____
□Special classes in school	_____	□Mental Retardation	_____
□Obsessive Compulsive D/O	_____	□Schizophrenia	_____
□Extreme fears or phobias	_____	□Eating Disorder	_____
□Manic Depressive or Bipolar	_____	□Victim of sexual abuse	_____
□Victim of physical abuse	_____	□Other	_____
□Rape victim	_____	□Jail Sentence	_____

Infectious Diseases

Does the patient have any infectious diseases? □No □Yes

If yes, please list:

_____

_____

_____