Shelby Psychological Services

Patient Registration Form

PATIENT INFORMATION					
Name		Birth Date	❒ Male ❒ Female	Social Security Number	
Street Address		City		State	Zip Code
School	Grade	Patient /Guardian Employer		Work Phone ( )	
Responsible Party's Email Address				Home Phone ( )	
Primary Care Physician Name:				Cell Phone ( )	
How Did you Hear About Us? ❒ Physician ❒ Internet ❒ Yellow Pages ❒ Insurance Co. ❒ Other _____					

INSURANCE INFORMATION (Please provide your insurance card for office to copy)			
Primary Insurance			
Policy Holder's Name	Birth Date	Employer	Group number
Policy Number	Patient's Relationship to Policy Holder		
Secondary Insurance			
Policy Holder's Name	Birth Date	Employer	Group number
Policy Number	Patient's Relationship to Policy Holder		
Person Responsible for Bill and address if different			

Your Signature

Acknowledges:

- Accuracy of above information and financial responsibility to pay any balance and attorney if required for account collection
- Notice of HIPAA and State of Alabama policy and practices to protect your health information
- Consent for me or my minor child to be evaluated and/or treated by Shelby Psychological Services
- Dr. Vance has a small therapy-dog-in-training at SPS – we understand it is our responsibility to inform SPS staff if we do not want to interact with the dog.

Authorizes:

- SPS to release information required to process my insurance claim and for insurance benefits to be paid to SPS
- Consent to release treatment information to SPS providers only in the event of an interoffice referral
- Consent to release requested information to the referring physician/source
- Consent to release information for insurance purposes, when required, with supervising providers.

I have read, understand and acknowledge/authorize the above.

Printed Name of Patient/Guardian_____

_____ _____

Signature of Patient/Guardian **Date**

ADULT PATIENT INFORMATION

(To be completed if patient is over 18 years of age)

Patient Name: _____

Primary Care Physician (PCP): _____

PCP Phone: _____ PCP Address: _____

_____

Patient Marital Status:_____

Spouse/significant other Name: _____

Home Phone:_____Work Phone:_____

Cell Phone: _____Can we contact? Yes__ No__

In case of Emergency please contact (other than spouse/significant other):

Name:_____

Phone: _____Cell:_____

Children:

Names	Age	Biological/Step/Adopted
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

Patient Occupation:_____

Name of Employer:_____

Highest level of education: _____

Military History: Yes_____ No_____

If yes, what branch: _____

Highest rank: _____ Discharge status: _____

Current Medications: _____

_____

Prescribing physician: _____Phone _____

Brief statement of Concerns and Goals of Treatment:

Shelby Psychological Services
FINANCIAL AGREEMENT

Patient/Guardian/Responsible Party Name:
_____

Please remember that insurance is considered a method of reimbursing the patient for the fee paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. Testing services are not always reimbursed. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance.

IN ORDER TO CONTROL THE COST OF BILLINGS, IT IS REQUESTED THAT THE CHARGES FOR OFFICE VISITS BE PAID AT THE TIME OF THE VISIT. **APPOINTMENTS NOT CANCELED 24 HOURS PRIOR TO THE SCHEDULED TIME WILL BE CHARGED AT THE REGULAR RATE.** Automated reminder calls are sent out as a courtesy. However, computers do sometimes malfunction and phone numbers change etc. **YOU ARE STILL RESPONSIBLE TO KEEP YOUR APPOINTMENTS OR CANCEL ON A TIMELY BASIS** even if the reminder system does not work.

_____Please initial

If a provider receives a subpoena with an order to appear for court proceedings regarding this case, it is the client/guardian's responsibility to reimburse the provider for their time. This includes preparation time, travel time and actual time at court at the cost of $200/hour. A retainer fee of $1000 is required at the time of the request. _____Please initial

If this account is assigned to an attorney for collection and/or suit, I agree to pay a reasonable attorney's fee and cost of collection. To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's record. I hereby assign all medical benefits, to include any major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance and/or other health plans to Shelby Psychological Services.

The assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Patient/Responsible Party Signature _____Date _____

PROMIS–29 Profile v1.0

Please respond to each question or statement by marking one box per row.

	Physical Function	**Without any difficulty**	**With a little difficulty**	**With some difficulty**	**With much difficulty**	**Unable to do**
PFA11 1	Are you able to do chores such as vacuuming or yard work?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
PFA21 2	Are you able to go up and down stairs at a normal pace?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
PFA23 3	Are you able to go for a walk of at least 15 minutes?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
PFA53 4	Are you able to run errands and shop?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
	Anxiety **In the past 7 days…**	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**
EDANX01 5	I felt fearful	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
EDANX40 6	I found it hard to focus on anything other than my anxiety	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
EDANX41 7	My worries overwhelmed me	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
EDANX53 8	I felt uneasy	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
	Depression **In the past 7 days...**	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**
EDDEP04 9	I felt worthless	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
EDDEP06 10	I felt helpless	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
EDDEP29 11	I felt depressed	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
EDDEP41 12	I felt hopeless	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
	Fatigue **During the past 7 days…**	**Not at all**	**A little bit**	**Somewhat**	**Quite a bit**	**Very much**
HI7 13	I feel fatigued	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
A3 14	I have trouble starting things because I am tired	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
	In the past 7 days…					
FATEXP41 15	How run-down did you feel on average?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

PROMIS–29 Profile v1.0

Fatigue

	In the past 7 days…	Not at all	A little bit	Somewhat	Quite a bit	Very much
FATEXP40 16	How fatigued were you on average?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Sleep Disturbance

	In the past 7 days…	Very poor	Poor	Fair	Good	Very good
Sleep109 17	My sleep quality was	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

	In the past 7 days…	Not at all	A little bit	Somewhat	Quite a bit	Very much
Sleep116 18	My sleep was refreshing	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Sleep20 19	I had a problem with my sleep	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Sleep44 20	I had difficulty falling asleep	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Satisfaction with Social Role

	In the past 7 days…	Not at all	A little bit	Somewhat	Quite a bit	Very much
SRPSAT07 21	I am satisfied with how much work I can do (include work at home)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
SRPSAT24 22	I am satisfied with my ability to work (include work at home)……	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
SRPSAT47 23	I am satisfied with my ability to do regular personal and household responsibilities	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
SRPSAT49 24	I am satisfied with my ability to perform my daily routines	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Pain Interference

	In the past 7 days…	Not at all	A little bit	Somewhat	Quite a bit	Very much
PAININ9 25	How much did pain interfere with your day to day activities?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PAININ22 26	How much did pain interfere with work around the home?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PAININ31 27	How much did pain interfere with your ability to participate in social activities?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PAININ34 28	How much did pain interfere with your household chores?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Pain Intensity

	In the past 7 days…											
Global07 29	How would you rate your pain on average?	☐ 0 **No pain**	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10 **Worst imaginable pain**

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐