NORTH COUNTRY BEHAVIORAL MEDICINE
SERVING THE COMMUNITY WITH COMPASSION

8 Broad Street
Plattsburgh, NY 12901
Phone: (518) 825-1555 Fax: (518) 825-1550

INTAKE FORM

The treatment and counseling work we do is unique to you, just as it is to each one of our patients. Before we get started we need to collect some general information from you.

GENERAL INFORMATION

First Name | Last Name | Gender

Date of Birth (MM/DD/YYYY) | Social Security Number

Address

City | State | Zip Code

Main Phone | Other Phone

Email

EMERGENCY CONTACT

First Name | Last Name

Phone | Relationship

Do you authorize this person to discuss care or treatment with the office in the case of an emergency?

☐ **YES** ☐ **NO**

INSURANCE INFORMATION

PRIMARY INSURANCE | **Policy Holder**

Policy Holder D.O.B. (MM/DD/YYYY) | Relationship

Policy Holder Address

City | State | Zip Code

Policy Number | **Group Number**

NORTH COUNTRY BEHAVIORAL MEDICINE
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SECONDARY INSURANCE **Policy Holder**

Policy Holder D.O.B. (mm/dd/yyyy) Relationship

Policy Holder Address

City State Zip Code

Policy Number **Group Number**

PARENT/GUARDIAN INFORMATION (If applicable)

First Name Last Name

Phone Relationship

First Name Last Name

Phone Relationship

MENTAL HEALTH HISTORY/STATUS

What problems are you seeking help for?

CURRENT MENTAL HEALTH TREATMENT

Are you currently receiving mental health services? ☐**YES** ☐**NO**

If yes, where are you receiving services? _____

If changing services, why are you making this change? _____

Is someone (other than a parent for a minor child) helping you complete these forms? ☐**YES** ☐**NO**

If yes, what is their name and role? _____

PAST MENTAL HEALTH TREATMENT

Have you ever been hospitalized for psychiatric reasons? ☐**YES** ☐**NO**

If yes, when and where? _____

Have you ever had outpatient treatment by a psychiatrist or psychiatric provider (e.g. NP or PA)? ☐**YES** ☐**NO**

If yes, when and by whom? _____

Have you ever received counseling or psychotherapy in the past? ☐**YES** ☐**NO**

If yes, when and by whom? _____

NORTH COUNTRY BEHAVIORAL MEDICINE
SERVING THE COMMUNITY WITH COMPASSION

MEDICATION QUESTIONNAIRE

Name:

Date: Date of Birth:

DIRECTIONS: Please place a check mark in the box that describes your experience with any of the medications listed below.

Generic Name	Trade Name	Helpful	Not Helpful	Current Use	History of Use	Adverse Reaction	Patient, Parent, Guardian or Physician/NPP Comments
ANTIDEPRESSANTS							
Amitriptyline	Elavil	☐	☐	☐	☐	☐	
Bupropion	Wellbutrin, Wellbutrin SR, Wellbutrin XL	☐	☐	☐	☐	☐	
Citalopram	Celexa	☐	☐	☐	☐	☐	
Clomipramine	Anafranil	☐	☐	☐	☐	☐	
Desipramine	Norpramin	☐	☐	☐	☐	☐	
Desvenlafaxine	Pristiq	☐	☐	☐	☐	☐	
Doxepin	Sinequan, Silenor	☐	☐	☐	☐	☐	
Duloxetine	Cymbalta	☐	☐	☐	☐	☐	
Escitalopram	Lexapro	☐	☐	☐	☐	☐	
Fluoxetine	Prozac, Sarafem	☐	☐	☐	☐	☐	
Fluvoxamine	Luvox, Luvox CR	☐	☐	☐	☐	☐	
Imipramine	Tofranil	☐	☐	☐	☐	☐	
Isocarboxazid	Marplan	☐	☐	☐	☐	☐	
Levomilnacipran	Fetzima	☐	☐	☐	☐	☐	
Milnacipran	Savella	☐	☐	☐	☐	☐	
Mirtazapine	Remeron, Remeron SolTab	☐	☐	☐	☐	☐	
Nefazodone	Serzone	☐	☐	☐	☐	☐	
Nortriptyline	Pamelor	☐	☐	☐	☐	☐	
Paroxetine	Paxil, Paxil CR	☐	☐	☐	☐	☐	
Phenelzine	Nardil	☐	☐	☐	☐	☐	
Selegiline Transdermal	Emsam	☐	☐	☐	☐	☐	
Sertraline	Zoloft	☐	☐	☐	☐	☐	
Tranylcypromine	Parnate	☐	☐	☐	☐	☐	
Trazodone	Desyrel, Oleptro	☐	☐	☐	☐	☐	
Venlafaxine	Effexor, Effexor XR	☐	☐	☐	☐	☐	
Vilazodone	Viibryd	☐	☐	☐	☐	☐	
Vortioxetine	Trintellix, Brintellix	☐	☐	☐	☐	☐	
ANTIPSYCHOTICS "major tranquilizers"							
Aripiprazole	Abilify	☐	☐	☐	☐	☐	
Asenapine	Saphris	☐	☐	☐	☐	☐	
Brexpiprazole	Rexulti	☐	☐	☐	☐	☐	
Cariprazine	Vraylar	☐	☐	☐	☐	☐	
Chlorpromazine	Thorazine	☐	☐	☐	☐	☐	
Clozapine	Clozaril, FazaClo, Versacloz	☐	☐	☐	☐	☐	
Fluphenazine	Prolixin, Prolixin Decanoate	☐	☐	☐	☐	☐	
Haloperidol	Haldol, Haldol Decanoate	☐	☐	☐	☐	☐	
Iloperidone	Fanapt	☐	☐	☐	☐	☐	

NORTH COUNTRY BEHAVIORAL MEDICINE
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MEDICATION QUESTIONNAIRE

Name:

Date: Date of Birth:

Generic Name	Trade Name	Helpful	Not Helpful	Current Use	History of Use	Adverse Reaction	Patient, Parent, Guardian or Physician/NPP Comments
Loxapine	Loxitane	☐	☐	☐	☐	☐	
Lurasidone	Latuda	☐	☐	☐	☐	☐	
Molindone	Moban	☐	☐	☐	☐	☐	
Olanzapine	Zyprexa, Zyprexa Zydis, Zyprexa Relprevv	☐	☐	☐	☐	☐	
Paliperidone	Invega, Invega Sustenna, Inrega Trinza	☐	☐	☐	☐	☐	
Perphenazine	Trilafon	☐	☐	☐	☐	☐	
Pimavanserin	Nuplazid	☐	☐	☐	☐	☐	
Quetiapine	Seroquel, Seroquel XR	☐	☐	☐	☐	☐	
Risperidone	Risperdal, Risperdal Consta, Risperdal M-Tab	☐	☐	☐	☐	☐	
Thioridazine	Mellaril	☐	☐	☐	☐	☐	
Thiothixene	Navane	☐	☐	☐	☐	☐	
Trifluoperazine	Stelazine	☐	☐	☐	☐	☐	
Ziprasidone	Geodon	☐	☐	☐	☐	☐	
ANXIOLYTICS "anti-anxiety" "minor tranquilizers"							
Alprazolam	Xanax, Xanax XR	☐	☐	☐	☐	☐	
Buspirone	BuSpar	☐	☐	☐	☐	☐	
Chlordiazepoxide	Librium	☐	☐	☐	☐	☐	
Clonazepam	Klonopin, Klonopin Wafers	☐	☐	☐	☐	☐	
Clorazepate	Tranxene	☐	☐	☐	☐	☐	
Diazepam	Valium	☐	☐	☐	☐	☐	
Hydroxyzine	Vistaril, Atarax	☐	☐	☐	☐	☐	
Lorazepam	Ativan	☐	☐	☐	☐	☐	
Oxazepam	Serax	☐	☐	☐	☐	☐	
ANTICHOLINESTERASE/ALZHEIMER'S AGENTS							
Donepezil	Aricept	☐	☐	☐	☐	☐	
Galantamine	Razadyne	☐	☐	☐	☐	☐	
Memantine	Namenda, Namenda XR	☐	☐	☐	☐	☐	
Rivastigmine	Exelon	☐	☐	☐	☐	☐	
Selegiline	Eldepryl	☐	☐	☐	☐	☐	
Tacrine	Cognex	☐	☐	☐	☐	☐	
ALCOHOL/DRUG/SMOKING CESSATION AGENTS							
Acamprosate	Campral	☐	☐	☐	☐	☐	
Buprenorphine/ Naloxone	Suboxone, Bunavail, Zubsolv	☐	☐	☐	☐	☐	
Bupropion	Zyban	☐	☐	☐	☐	☐	
Disulfiram	Antabuse	☐	☐	☐	☐	☐	
Methadone	Dolophine	☐	☐	☐	☐	☐	
Naltrexone	ReVia, Vivitrol	☐	☐	☐	☐	☐	

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MEDICATION QUESTIONNAIRE

Name:

Date: Date of Birth:

Generic Name	Trade Name	Helpful	Not Helpful	Current Use	History of Use	Adverse Reaction	Patient, Parent, Guardian or Physician/NPP Comments
Varenicline	Chantix	☐	☐	☐	☐	☐	
MOOD STABILIZING AGENTS/AED's							
Carbamazepine	Tegretol, Tegretol XR	☐	☐	☐	☐	☐	
Fluoxetine/Olanzapine	Symbyax	☐	☐	☐	☐	☐	
Gabapentin	Neurontin	☐	☐	☐	☐	☐	
Lamotrigine	Lamictal, Lamictal XR, Lamictal ODT	☐	☐	☐	☐	☐	
Levetiracetam	Keppra, Keppra XR	☐	☐	☐	☐	☐	
Lithium	Eskalith, Eskalith CR, Lithobid	☐	☐	☐	☐	☐	
Oxcarbazepine	Trileptal	☐	☐	☐	☐	☐	
Tiagabine	Gabitril	☐	☐	☐	☐	☐	
Topiramate	Topamax	☐	☐	☐	☐	☐	
Valproate	Depakene, Depakote, Depakote ER, Valproic Acid	☐	☐	☐	☐	☐	
PSYCHOSTIMULANTS							
Amphetamine Salts	Adderall, Adderall XR	☐	☐	☐	☐	☐	
Armodafinil, Pemoline	Nuvigil, Cylert	☐	☐	☐	☐	☐	
Atomoxetine	Strattera	☐	☐	☐	☐	☐	
Dexmethylphenidate	Focalin, Focalin XR	☐	☐	☐	☐	☐	
Dextroamphetamine	Dexedrine, Dextrostat	☐	☐	☐	☐	☐	
Lisdexamfetamine	Vyvanse	☐	☐	☐	☐	☐	
Methylphenidate	Ritalin, Ritalin SR, Ritalin LA, Concerta, Metadate ER/CD, Methylin, QuilliChew ER, Quillivant XR	☐	☐	☐	☐	☐	
Methylphenidate Transdermal	Daytrana	☐	☐	☐	☐	☐	
Modafinil	Provigil	☐	☐	☐	☐	☐	
SEDATIVE/HYPNOTICS							
Chloral Hydrate	Noctec	☐	☐	☐	☐	☐	
Eszopiclone	Lunesta	☐	☐	☐	☐	☐	
Flurazepam	Dalmane	☐	☐	☐	☐	☐	
Ramelteon	Rozerem	☐	☐	☐	☐	☐	
Suvorexant	Belsomra	☐	☐	☐	☐	☐	
Temazepam	Restoril	☐	☐	☐	☐	☐	
Triazolam	Halcion	☐	☐	☐	☐	☐	
Zaleplon	Sonata	☐	☐	☐	☐	☐	
Zolpidem	Ambien, Ambien CR, Intermezzo, Edluar	☐	☐	☐	☐	☐	
OTHER							
Benztropine	Cogentin	☐	☐	☐	☐	☐	

NORTH COUNTRY BEHAVIORAL MEDICINE
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MEDICATION QUESTIONNAIRE

Name:

Date: Date of Birth:

Generic Name	Trade Name	Helpful	Not Helpful	Current Use	History of Use	Adverse Reaction	Patient, Parent, Guardian or Physician/NPP Comments
Clonidine	Catapres, Kapvay	☐	☐	☐	☐	☐	
Cyproheptadine	Periactin	☐	☐	☐	☐	☐	
Diphenhydramine	Benadryl	☐	☐	☐	☐	☐	
Guanfacine	Tenex, Intuniv	☐	☐	☐	☐	☐	
Prazosin	Minipress	☐	☐	☐	☐	☐	
Propranolol	Inderal	☐	☐	☐	☐	☐	
Trihexyphenidyl	Artane	☐	☐	☐	☐	☐	
HERBAL PREPARATIONS							

☐ I am unable or unwilling to complete this form.

☐ I have completed this form to the best of my ability.

Signature of Patient/Parent/Guardian: **Date:**

☐ Reviewed in person with the patient.

☐ Reviewed over the phone with the parent/guardian of the patient.

☐ Reviewed in person with the patient and / or parent/guardian of the patient.

Signature of Psychiatrist/NPP: **Date/Time:**

NORTH COUNTRY BEHAVIORAL MEDICINE
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GENERAL MEDICAL HISTORY

Primary Care Physician: _____

Please list any medical problems you may have below:

_____

_____

_____

_____

_____

Please list any serious medical procedures you have had in the past:

_____

_____

_____

_____

_____

Are you on any medications for any general medical problems you may have? ☐ **YES** ☐ **NO**

If yes, which ones? _____

Do you have any allergies to medications? ☐ **YES** ☐ **NO**

If yes, which ones? _____

NORTH COUNTRY BEHAVIORAL MEDICINE
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Alcohol, Drug, and Tobacco Use

Describe your use of alcohol:

Describe your use of recreational drugs:

Describe your use of tobacco:

Family Medical History

List any history of illness (mental or other) and substance abuse among blood relatives:

Mother's side **Father's side**

SOCIAL HISTORY

Birth place: Where did you grow up?

Did your parents get divorced as a child? ☐ **YES** ☐ **NO**

If so, how old were you when they separated?

Father's occupation growing up:

Mother's occupation growing up:

How many siblings do you have?

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Did you have any early development problems as a child?

Are you/were you a victim of any form of physical/sexual/emotional abuse?

Highest Level of Education:

Please list the last three jobs you have had below:

Current employment:

Are you currently in a romantic relationship? ☐ **YES** ☐ **NO** Duration: _____

Describe your relationship:

Spouse or partner's current occupation:

NORTH COUNTRY BEHAVIORAL MEDICINE
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Do you have any children? ☐ **YES** ☐ **NO** How many? _____

What are your children's names and ages?

What activities do you enjoy doing?

Have you ever been convicted of any crimes, served time, or been on probation? ☐ **YES** ☐ **NO**

Details:

Please list any additional notes that you think would be helpful for treatment below:

NORTH COUNTRY BEHAVIORAL MEDICINE
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CONSENT TO TREATMENT

First Name: Last Name:

You are about to take a very important step in your mental health treatment, and you are seeing a mental health professional. As your mental health provider, we will be entering into a protected relationship. Treatment might involve a multidimensional family approach. Due to this consent is needed for all those attending sessions.

We are treating you and we will do our best to accurately diagnose you and design a comprehensive treatment plan that will enable you to continue with a normal emotional development. This may include recommendations of therapy, or medications. This is all part of the service of a mental health professional. We will also work with your primary care physician to assure coordination of care.

_____**(Initial)**

You are our patient and have confidentially rights. Confidentiality does not apply under certain situations: We are obligated by law to report any suspicion of child abuse. This includes physical or sexual abuse. Also, we have a duty to protect if we suspect anyone is in danger of killing themselves or has made threats to hurt someone else. Except in these rare situations, your child has the right to keep particular topics confidential from even his/her guardian. Please respect this confidentiality. Again, if there is any concern of harm, suicide or other dangerous behavior, we will inform you.

If I require or think it is in your best interest to communicate with an outside source, I will request a release of information. To assure good therapeutic care, frequent appointments are required. Unless arranged otherwise, patients that have not been seen in 6 months may be considered inactive. A new evaluation will be required for any inactive patient to be seen.

_____**(Initial)**

I, _____(patient), do hereby seek and consent to take part in the treatment provided by North Country Behavioral Medicine PLLC. If I am attending group services I also understand and consent that confidentiality still applies and that North Country Behavioral Medicine PLLC is not liable for group members breaking confidentiality. I understand that developing a treatment plan with this provider and regularly reviewing our work toward the treatment goals are in my best interest. I agree to play an active role in this process. I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this mental health professional.

_____**(Initial)**

NORTH COUNTRY BEHAVIORAL MEDICINE
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I am aware that I may stop treatment with this mental health professional at any time. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)
_____**(Initial)**

I am aware that if I attempt to contact my provider through phone, email, text, or any other form of communication over the Internet, my information may not be completely secure. In the event that my information is intercepted, North Country Behavioral Medicine is not responsible for the breach of patient privacy. Below are the approved contact means to leave messages on or respond to if contacted:

Phone: Email:

_____ **(Initial)**

_____	_____	_____
Patient Name (please print)	Patient Signature	Date

NORTH COUNTRY BEHAVIORAL MEDICINE
SERVING THE COMMUNITY WITH COMPASSION

LIFETIME INSURANCE AUTHORIZATION AND RELEASE OF INFORMATION

First Name: Last Name:

Release of Information: I, the subscriber named below, authorize North Country Behavioral Medicine PLLC and any providers working under North Country Behavioral Medicine PLLC examining or treating me to release any and all information pertaining to my treatment to any third party payer (such as my insurance company or a government agency) as needed to determine a claim for payment for such treatment and or diagnosis.

Physician Insurance Assignment: I, the below named subscriber, herby authorize payment directly to North Country Behavioral Medicine PLLC for my treatment at this office that is otherwise payable to me for their services as described.

Medicare/Medicaid – Patient's certification authorization to release information and payment request, I certify that the information given by me in applying for payment under Title XVIII/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to be released to Social Security Administration/Division of Family Services or its intermediaries or carries any information needed for this of a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the physician treating me.

I PERMIT A COPY OF THESE AUTHORIZATIONS AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL WHICH IS ON FILE AT THE PHYSICIAN'S OFFICE.

This assignment will remain in effect until revoked by me writing.

Please remember that insurance is considered a method of reimbursing the patient for fees 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. I understand it's my responsibility to pay any deductible amount co-insurance, or any other balance not paid for by my insurance or third payer within a reasonable period of time not to exceed 90 days.

Patient Name (please print)

Patient/Guardian Signature Date

Insurance Company

NORTH COUNTRY BEHAVIORAL MEDICINE
SERVING THE COMMUNITY WITH COMPASSION

HIPPA NOTICE/PRIVACY PRACTICES

First Name: Last Name:

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

North Country Behavioral Medicine PLLC, 8 Broad Street, Plattsburgh, NY 12901, (518) 825-1555

We understand the importance of privacy and are committed to maintaining the confidentiality of your information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this notice, please contact our office.

See front office for “HIPPA Detail” forms.

Patient Name (please print)

Patient/Guardian Signature Date

North Country Behavioral Medicine, PLLC
8 Broad Street
Plattsburgh, NY 12901

MRN

Name

DOB

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

BY SIGNING THIS FORM, YOU AUTHORIZE THE NORTH COUNTRY BEHAVIORAL MEDICINE, PLLC TO RELEASE OR OBTAIN YOUR HEALTH INFORMATION TO THE PARTIES LISTED IN SECTION C BELOW. PLEASE COMPLETE ALL SECTIONS. INCOMPLETE FORMS CAN PREVENT OR DELAY RELEASE.

Section A:

Patient Name:_____ **Date of Birth:**_____

Patient Address:_____ **City:** _____

State & Zip Code:_____ **Phone Number:** _____

Section B: Reason for Release of Information:

☐ Medical Care	☐ Personal Records	☐ Insurance/ Payment	☐ Workers' Compensation	☐ School:
☐ Attorney/Legal Proceedings	☐ Provider Transfer	☐ Disability	☐ Other:	

Section C: Party to Receive or Obtain Information From:

☐ Release a copy of my protected health information (PHI) **to**:

☐ Obtain a copy of my PHI **from**:

☐ I decline to have PHI shared **to** or **from** North Country Behavioral Medicine, PLLC (except as allowed by HIPAA regulation)

Name:	
Address:	
Phone Number:	Fax Number:

Delivery Method : ☐ Mail ☐ Fax

☐ E-mail address: _____ **(only for patients, patient guardian(s), or next of kin for deceased patients).**

☐ Other: _____

Please note that if the request is for an unencrypted electronic delivery method, it may not be secure. The requester acknowledges and accepts risk associated with unencrypted electronic transmission. It is the recipient's responsibility to protect the information once received.

Section D: Description of the Information to be released/obtained:

The date of service and type(s) of information to be released or obtained are as follows:

The records to be released will cover the time period from _____ to _____

Records from a specific Provider/Clinic: _____

☐ Discharge Summary	☐ Emergency Dept. Notes	☐ Cardiology Testing Reports	☐ Billing
☐ Inpatient Notes	☐ Laboratory/Pathology Reports	☐ Radiology Reports	☐ Immunizations
☐ Office or Clinic Notes	☐ Operative Reports	☐ Radiology Images	☐ History and Physical
☐ Consults			

☐ Other: _____

North Country Behavioral Medicine, PLLC
8 Broad Street
Plattsburgh, NY 12901

MRN

Name

DOB

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Section E:

For certain sensitive information, you must initial in the box below for the information to be included in your release.

SENSITIVE HEALTH INFORMATION This form authorizes UVM Medical Center to release the following types of information, **ONLY IF** you place your initials in the space provided:

_____ Mental Health Records (including Psychotherapy) _____Confidential HIV/AIDS Information

_____ Sexually Transmitted disease (STI) records _____Genetic Testing Results

_____ Substance, Drug, Alcohol Use Disorder Records from a 42 CFR Part 2 program

- Certain alcohol/drug treatment information from a "Part 2 Program" must be accompanied by the required statement regarding prohibition of re-disclosure. (42 CFR Part 2)
- For New York sites: Confidential HIV/AIDS information must be accompanied by the required statements regarding prohibition of disclosure when required by law. Information from certain mental health clinical records may be released pursuant to this authorization to the parties identified, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person.

I understand and agree that:

- I may be charged a fee for copies in accordance with state and federal law. The fee schedule is available by contacting Health Information Management by **Phone: (518) 825-1555 or Fax: (518) 825-1550.**
- I can revoke (cancel) this authorization at any time by submitting my request in writing to the entity to whom I submitted this authorization form. My revocation will not apply to information that has already been released in reliance upon this authorization.
- Information used or disclosed pursuant to this authorization may be re-disclosed by the recipient and may no longer be protected under federal and state law, unless specific re-disclosure laws apply.
- Signing this form is voluntary. I do not need to sign this form to receive health care services from North Country Behavioral Medicine, PLLC.
- **This authorization will expire on _____. If I do not specify an expiration date, this authorization will expire one (1) year from the date signed.**

When the patient is a minor or is not competent to provide authorization, the signature of a parent, legal guardian or other legal representative is required. If the patient is between the ages of 12-17, the patient will need to authorize the release of records for some services. Documentation of a legal representative's authority may be required to process this form.

_____ _____ _____
Signature of Patient Date Time

_____ _____ _____
Signature of Parent or Legal Representative Date Time

_____ _____
Print Name Relationship (if signed by Parent/Legal Representative)

FOR OFFICE USE ONLY		
I have authenticated the identity of the person named in this authorization form via ☐Photo ID ☐Other		
Employee Signature	**Date Received**	**Date Completed**

NORTH COUNTRY BEHAVIORAL MEDICINE
SERVING THE COMMUNITY WITH COMPASSION

APPOINTMENT CANCELLATION AGREEMENT

First Name: Last Name:

North Country Behavioral Medicine requires that all appointments be cancelled no later than **24 business hours before the appointment is scheduled (Monday through Friday 8:00 am to 5:00 pm).**

We understand there are occasionally circumstances beyond anyone's control causing appointments to be cancelled at the last minute. In an attempt to be fair, for well-established patients we allow for 3 late cancellations in a 12 month period. Upon the third late cancellation, a warning letter will be sent to the patient informing that any further late cancelled appointments **will result in a charge of $50**.

If an initial assessment is cancelled with notice of less than 24 business hours, this will result in a $100 charge. We do not waive charges for initial evaluations.

ALL NO SHOWS WILL RESULT IN A $100 FEE FOR INITIAL ASSESSMENTS AND $50 FEE FOR FOLLOW UP VISITS. REPEATED NO SHOWS MAY RESULT IN THE CLOSURE OF YOUR FILE.

If you are a Medicaid patient (including Managed Medicaid Plans or Medicare/Medicaid) you are not subject to the $50 fee, however after 3 late cancellations within 12 months, patients may be placed on same day status or their file with our clinic will be closed. If a new assessment is cancelled with less than 24 hours business hours' notice, your file may be closed. NO SHOWS FOR INITIAL ASSESSMENTS AND MORE THAN ONE NO SHOW FOR FOLLOW UPS OVER 12 MONTHS, WILL RESULT IN THE CLOSURE OF YOUR FILE.

While we do remind you of your appointment, it is your responsibility to call the office at (518) 825-1555, to cancel.

Printed Name

Signature Date

I understand that the office of North Country Behavioral Medicine PLLC will attempt to bill my insurance for services rendered, however ***if my insurance does not pay, for whatever reason, I am responsible for any remaining balance.*** This may include deductibles, copays, or out of pocket expenses.

My signature acknowledges:

- In the case of a Psychiatric Emergency I will call 911 or go to the nearest hospital
- 72 business hours is required for any prescription renewals.
- I will adhere to the guidelines above to the best of my ability.

Patient Name (please print)

Patient/Guardian Signature Date

NORTH COUNTRY BEHAVIORAL MEDICINE
SERVING THE COMMUNITY WITH COMPASSION

STATEMENT OF NON-DISCRIMINATION

This Practice does not differentiate or discriminate in the treatment of Persons on the basis of, to include, but not limited to: veteran status, race, ethnicity, mental or physical disability or medical condition, sexual orientation, gender, claims experience, evidence of insurability (including conditions arising out of acts of domestic violence), genetic information, color, sex, age, religion, national origin, place of residence, health history, health status, handicap, source of payment or status as a Person.

Signature	Printed Name	Date

North Country Behavioral Medicine, PLLC

Patient Review of Systems Questionnaire

NAME:_____DATE: _____

Please check if you've had any of these symptoms within the last three weeks:

Constitutional
- ☐ Coldness
- ☐ Sweating
- ☐ Dry mouth
- ☐ Fatigue
- ☐ Fever

Eye, Ear, Nose, Mouth/Throat
- ☐ Blurred vision
- ☐ Corrective lenses: _____
- ☐ Double vision
- ☐ Ringing in ears
- ☐ Hearing loss
- ☐ Frequent colds
- ☐ Frequent sore throats
- ☐ Difficulty swallowing

Cardiovascular
- ☐ Chest pain
- ☐ Leg/Arm swelling
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Palpitations/skipped beats
- ☐ Fast heart beat

Respiratory
- ☐ Coughing
- ☐ Shortness of breath
- ☐ Wheezing

GI System
- ☐ Abdominal pain
- ☐ Anal problems
- ☐ Blood in stools/black stools
- ☐ Constipation/hard stools
- ☐ Diarrhea/unformed stools
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting

Genitourinary

Women:
- ☐ Vaginal discharge
- ☐ Menstrual cramps/pain
- ☐ Irregular periods
- ☐ STD

Men:
- ☐ STD
- ☐ Penile discharge
- ☐ Testicular swelling
- ☐ Testicular tenderness

Urinary
- ☐ Frequency
- ☐ Incontinence
- ☐ Recurrent infections
- ☐ Urgency
- ☐ Urethral discharge

Musculoskeletal
- ☐ Use of assistive device:_____
- ☐ Back pain
- ☐ Joint pain
- ☐ Stiffness
- ☐ Swelling
- ☐ Weakness

Skin/Hair/Nails
- ☐ Dry skin
- ☐ Hair loss
- ☐ Lacerations (cuts)
- ☐ Rashes
- ☐ Scars

Breast/Chest
- ☐ Breast feeding
- ☐ Nipple discharge
- ☐ Pain
- ☐ Swelling

Neurological
- ☐ Confusion
- ☐ Dizziness
- ☐ Headaches
- ☐ Head injury
- ☐ Memory problems
- ☐ Migraines
- ☐ Numbness
- ☐ Seizures
- ☐ Fainting
- ☐ Tingling
- ☐ Tremors

Endocrine
- ☐ Cold intolerance
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Excess urination
- ☐ Heat intolerance
- ☐ Weight gain
- ☐ Weight loss

Hematological
- ☐ Bruising
- ☐ Excessive bleeding
- ☐ Lumps/swelling

Allergies
- ☐ Drug
- ☐ Environment
- ☐ Seasonal
- ☐ Food

OTHER:

Patient Signature:

_____

Vital Signs (provider to enter):

BP: _____(Sitting)

PR: _____ **RR**: _____

O2: _____ **Temp**: _____

Height: _____**Weight:** _____