

Compassionate Solutions, Inc
at ASSOCIATES IN BRIEF THERAPY, INC.
4346 Starkey Road, Suite 1
Roanoke, VA 24018
(540) 772-8043

New Patient Information Sheet
(PLEASE PRINT)

PATIENT INFORMATION:

Patient's Name _____
Last Name First Name Middle Initial

Responsible Party (if a minor) _____

Mailing Address (Street and/or PO Box) _____ Apt # _____
City State Zip Code _____

Home Phone _____ Cell Phone _____

Email Address: _____ Family Physician _____

Sex: Male Female Date of Birth _____ Age _____ Pastor: _____

Single Married Divorced Widowed Separated Social Security Number _____

Patient Employer _____ Work Phone _____

Address _____ City State Zip _____

Occupation _____

In Case of Emergency, Please Contact: _____ Phone _____

PARENT/SPOUSE INFORMATION:

Spouse/Parent _____ Employer _____

Work Phone _____

Address _____ City State Zip _____

Occupation _____ Social Security Number _____

INSURANCE INFORMATION:

Primary Insurance Company _____ Phone Number _____

Subscriber's Identification Number _____ Group Number _____

Subscriber's Name _____ Relationship to Patient _____

RELEASE OF INFORMATION:

I authorize M. Rizwan Ali, M.D. to release any medical and billing information to any physician involved in my treatment, to any healthcare facility where I may seek treatment, and to any insurance company or other entity which is directly or indirectly responsible for payment or review of services by Dr. Ali.

(Patient or Responsible Person)

(Date)

Communication Between You and Your Therapist

Occasionally it will be necessary our office to contact you regarding appointments or other matters about counseling. This permission form will help us know when and how to contact you in ways which are comfortable for you.

By giving permission for us to contact you in one or more of the ways listed below, you are agreeing for us to leave messages and information. We will always try to be discrete in any messages we leave, but we cannot guarantee confidentiality once the message is left.

Home

Yes No May we contact you at your home telephone number?
If yes, home phone number: _____

Yes No If no one answers may we leave a message?
Preferred times/hours for message: _____

Work

Yes No May we contact you at your work telephone number?
If yes, work phone number: _____ ext: _____

Yes No If no one answers may we leave a message?
Preferred times/hours for message: _____

Cell Phone & Pager

Yes No May we contact you at your cell telephone number?
If yes, cell phone number: _____

Yes No If no one answers may we leave a message?
Preferred times/hours for message: _____

Yes No May we contact you at your pager number?
If yes, pager number: _____

E-Mail Appointment Reminder

Yes No **Would you like us to remind you of your appointment via your e-mail address?** If yes, please fill in your e-mail address: _____
You should receive your e-mail reminder 1 day prior to your appointment. The e-mail reminder will replace the phone call reminder. (Please print your e-mail address legibly. We are not responsible for incorrectly entered addresses that may electronically transmit to another e-mail address due to illegible handwriting.)

Note: It is unethical for therapists to give out personal telephone numbers, home addresses, or personal e-mail addresses. If you need to contact us, always call and leave your messages at our office number: (540) 772-8043.

Client Name: _____ Date: _____

Client or Guardian Signature: _____

Compassionate Solutions, Inc.
M. Rizwan Ali, M.D.
Board Certified Psychiatrist

Location: Associates In Brief Therapy, Inc.
4346 Starkey Road, Suite 1
Roanoke, VA 24018
(540) 772-8043

Date: _____ Name: _____

DOB: _____ Age: _____ Gender: _____ Race: _____ Marital Status _____

Medical Questionnaire

1. What is the major problem for which you are seeking help at this time?

2. When did this problem begin?

3. Have you ever had this problem before in your life? If so, when:

4. Do you have any of the following:

<input type="checkbox"/> Tearfulness	<input type="checkbox"/> Feelings of hopelessness	<input type="checkbox"/> Increased smoking
<input type="checkbox"/> Feelings of sadness	<input type="checkbox"/> Feelings of helplessness	<input type="checkbox"/> Increased drinking
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Difficulty sleeping	

5. Medication Allergies:

6. Current Medications: (Use the back of this sheet if necessary)

Medication	Strength	Frequency	Date started	Prescribed by

7. **Vitamins/ Herbal Remedies:**

8. **Please list all psychiatric medications you have ever taken including anti-depressants, mood stabilizers, anti-psychotics, tranquilizers, sleeping pills and anti-seizure medications:** (Use the back of this sheet if necessary)

Medication	Strength	Frequency	Date started	Prescribed by

9. **Please check below if you have had or have any of the following medical conditions:**

<input type="checkbox"/> Arthritis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> PMS
<input type="checkbox"/> Stomach ulcers	<input type="checkbox"/> Head injury/concussion	<input type="checkbox"/> Asthma
<input type="checkbox"/> Hyperthyroidism	<input type="checkbox"/> Seizures	<input type="checkbox"/> Other Respiratory Problems
<input type="checkbox"/> Hypothyroidism	<input type="checkbox"/> Heart attack	<input type="checkbox"/> Cancer
<input type="checkbox"/> Kidney problems	<input type="checkbox"/> Angina	<input type="checkbox"/> Menstrual Problems: _____
<input type="checkbox"/> Colitis	<input type="checkbox"/> High blood pressure	_____
<input type="checkbox"/> Chronic Pain	<input type="checkbox"/> Urinary retention	<input type="checkbox"/> Pregnancy: _____ times
<input type="checkbox"/> Lupus	<input type="checkbox"/> Migraines	<input type="checkbox"/> Miscarriage: _____ times
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Chronic headaches	<input type="checkbox"/> Surgery: _____

10. **List all medical conditions for which you are currently being treated by a physician:**

11. **List all psychiatric hospitalizations:** (Use back of this sheet if necessary)

Hospital	Location	Dates	Reason	Doctor's Name

12. **Alcohol Use per week:** Beer (12 oz cans)_____ Liquor_____ Wine_____ Other: _____

13. **Drug Use:** (Use the back of this sheet if necessary)

Drug	Frequency	Date started	Date stopped

14. **List the dates of any DUI's, traffic accidents or legal problems involving alcohol and/or drug use:**

15. **Caffeinated Drinks per day:** _____

16. **Tobacco Use:** _____

17. **Family History:**

Mother's age: _____ Health Status: _____ If deceased, year and cause of death: _____

Father's age: _____ Health Status: _____ If deceased, year and cause of death: _____

Brothers: _____

Sisters: _____

Has any family member ever had a problem with drugs and/or alcohol? If so, who and what? _____

Has any member of your family ever had any history of depression, anxiety, or other mental problems? Any history of suicide? _____

18. **Describe any childhood trauma/major illness:**

19. **Please list all marriages:**

20. Please list children and their ages:

21. Please list last 5 years of employment:

22. Have you ever had a work related injury or been on Worker's Compensation? If so, for what and when:

23. Are you on Social Security Disability? If so when did it begin and for what reason?

24. Highest Level of Education:

25. Were you ever in the military? If so, when, what division and type of discharge?

Compassionate Solutions, Inc
at ASSOCIATES IN BRIEF THERAPY, INC.
M. Rizwan Ali, M.D.
Board Certified Psychiatrist

4346 Starkey Road, Suite 1
Roanoke, VA 24018
(540) 772-8043

Patient Name: _____ **Date:** _____

ASSIGNMENT AND PROMISE TO PAY: In consideration of medical services rendered to me or at my request, I assign to Dr. Ali to the extent necessary to satisfy my outstanding indebtedness, the right to receive all sums payable to me or on my behalf under the terms of any health or liability policy or other arrangement or plan with a third party that provides for payment for medical or health care services. I understand that I owe and unconditionally agree to pay to Dr. Ali the full amount charged for health care services rendered to me or my dependents that are not paid on my behalf by a third party within 60 days of the date medical services are rendered. I also agree to pay reasonable attorney and collection fees if my account is placed in collection.

(Patient or Responsible Party) (Date)

MEDICARE SIGNATURE AUTHORIZATION: I request that payment of Medicare benefits be made on my behalf to Dr. Ali for services rendered. I authorize that release of information to the Health Care Financing Administration needed to determine these benefits.

(Patient or Responsible Party) (Date)

STATEMENT OF UNDERSTANDING/CONSENT FOR TREATMENT:

Welcome. Before you see Dr. Ali, you are requested to review the following information, and if you have any questions, please ask a member of our staff or Dr. Ali.

Sharing personal problems can be difficult and every effort is made to maintain your confidentiality. Unless written permission is obtained from you, Dr. Ali will not release or share any information you discuss except where required by law or as previously stated for billing purposes. If Dr. Ali believes that you or another person is at risk of harm or that there is a case of child or elder abuse, Dr. Ali is required by law to inform the appropriate agency or individual. In addition, a court may order a release of information, and Dr. Ali will comply with the judge's order.

By my signature below:

I acknowledge that I have read the above **STATEMENT OF UNDERSTANDING** and give my consent for treatment. If my dependents are under the age of 18 and I am the primary custodial parent or have joint custody, I hereby give consent for treatment.

If unable to keep an appointment, I acknowledge that I will notify the office at least 24 hours before my scheduled appointment time or I will be charged a \$25 *late cancellation fee*. If I fail to show up for my scheduled appointment and do not give 24 hour notice, I will be charged a \$45 *no show fee*.

I authorize the release of all medical information necessary to process insurance claims and authorize payment directly to Dr. Ali for medical services rendered to me. I also understand that I am financially responsible for the charges not covered or authorized by my insurance company.

I give permission for Dr. Ali to request from and to release pertinent health information regarding my current treatment to my primary care or family physician, Dr. _____ phone number: _____, for the purpose of facilitating coordination of care.

Signature of Patient/Parent or Legal Guardian: _____ **Date:** _____