

**-FOR OFFICE USE ONLY-**

**CLINICIAN #** \_\_\_\_\_ **ACCOUNT #** \_\_\_\_\_ **INSURANCE** \_\_\_\_\_

**PLEASE COMPLETE AND SIGN ALL PAGES WHERE INDICATED. ALL INFORMATION MUST BE COMPLETED.**  
(PLEASE PRINT)

**DATE:** \_\_\_\_\_

**PATIENT**  
**FIRST NAME** \_\_\_\_\_ **M.I.** \_\_\_\_\_ **PATIENT**  
**LAST NAME** \_\_\_\_\_ **SEX**  
**M** \_\_\_\_\_ **F** \_\_\_\_\_  
**STREET ADDRESS** \_\_\_\_\_ **DATE OF BIRTH** \_\_\_\_\_  
**CITY, STATE, ZIP CODE** \_\_\_\_\_  
**\*PATIENT SOCIAL SECURITY NUMBER\*** \_\_\_\_\_ **DRIVER LICENSE#** \_\_\_\_\_  
**NAME/PHONE NUMBER OF PERSON TO CONTACT IN CASE OF AN EMERGENCY** \_\_\_\_\_

**FOR PATIENTS UNDER 18 YEARS OF AGE:**

<b>GUARDIAN NAME</b> _____	<b>GUARDIAN NAME</b> _____
<b>GUARDIAN ADDRESS</b> _____	<b>GUARDIAN ADDRESS</b> _____
<b>CITY, STATE, ZIP CODE</b> _____	<b>CITY, STATE, ZIP CODE</b> _____
<b>GUARDIAN TELEPHONE #</b> _____	<b>GUARDIAN TELEPHONE #</b> _____
<b>*SOCIAL SECURITY *</b> _____	<b>*SOCIAL SECURITY *</b> _____
<b>*DATE OF BIRTH*</b> _____	<b>*DATE OF BIRTH*</b> _____
<b>DRIVERS LICENSE#</b> _____	<b>DRIVERS LICENSE#</b> _____

**PRIMARY INSURANCE:**

**INSURANCE COMPANY NAME** \_\_\_\_\_  
**I.D. NUMBER** \_\_\_\_\_ **GROUP NUMBER** \_\_\_\_\_  
**POLICY HOLDER NAME** \_\_\_\_\_ **RELATIONSHIP** \_\_\_\_\_ **DATE OF BIRTH** \_\_\_\_\_  
**EMPLOYER NAME** \_\_\_\_\_

**SECONDARY INSURANCE:**

**INSURANCE COMPANY NAME** \_\_\_\_\_  
**I.D. NUMBER** \_\_\_\_\_ **GROUP NUMBER** \_\_\_\_\_  
**POLICY HOLDER NAME** \_\_\_\_\_ **RELATIONSHIP** \_\_\_\_\_ **DATE OF BIRTH** \_\_\_\_\_  
**EMPLOYER NAME** \_\_\_\_\_

**IF THERE ARE INSURANCES IN ADDITION TO THOSE LISTED ABOVE AND IF THERE ARE CHANGES TO THE INSURANCE POLICIES DURING YOUR TREATMENT PLEASE NOTIFY THE FRONT DESK!!!**

**PAGE 1 (CONTINUE TO PAGE 2)**

## CONSENT TO TREATMENT & DIAGNOSTIC SERVICES

I understand that the services my dependent or I will receive are based on currently accepted practice in the fields of mental health. I also understand that the outcome of treatment cannot be guaranteed and that services continue only with my voluntary consent.

I understand that my records or the records of my dependent are confidential. These records can be released only as allowed by law under the statutes of the State of Michigan and federal guidelines, or as allowed by my signature on a release form, with the exceptions written below.

If any service is paid for by an insurance company, either in part or full, I understand that the insurance company or its agents have the right to examine my records at any time. I authorize the examination of my or my dependent's client records by them as they require for reimbursement and verification of services. I also understand that it may be necessary to release information regarding me or my dependent to a Case Manager or insurance verifier from my insurance company in order to process services. I also give my permission to release any information to my insurance company that is required to process insurance claims for services provided my dependent or me.

State of Michigan law requires that certain communicable diseases be reported to the Michigan Department of Health. If it is determined that my dependent or I have such a disease, I consent to disclosure of this to the Michigan Department of Health.

Federal laws and regulations do not protect any information about a crime committed by a client either at a treatment program, or against any person who works for a program, or about any threat to commit such a crime.

Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities.

**I understand that fees for services are to be paid at the time of the appointment unless other arrangements have been made. If my insurance company does not cover any fees or any portion of fees for the services my dependent or I have received, I accept responsibility for them. If maximum insurance benefits have been reached, I will be responsible for any fees for services subsequently rendered.**

I agree to provide information for the development of the treatment plan to be used. **I will keep scheduled appointments. I accept that I am financially responsible for all scheduled appointments and am aware that any appointment that is missed without my giving 24 hours notice may be billed to me because insurance companies will not pay for missed appointments or late cancellations. I understand that I may be billed for these appointments at the usual fee.** If treatment or diagnostic evaluation is terminated by my choice, or because of violation of above rules, I agree to pay all outstanding fees existing at the time of termination.

I understand that it might be necessary to reach me by mail or by telephone during or after my or my dependent's contact for purpose of confirming or scheduling appointments, billing and payment issues, completing forms, conducting surveys, and any necessary follow-up.

**PAGE 2 (CONTINUE TO PAGE 3)**

Cheryl Mazzara MD  
19900 Ten Mile Road  
St. Clair Shores, MI 48081

DUE TO HIPAA LAWS, IF YOU ARE 18 OR OVER, WE ARE UNABLE TO SPEAK TO ANYONE OTHER THAN YOURSELF REGARDING BILLS OR TREATMENT. IF YOU WANT TO ALLOW US TO SPEAK WITH SOMEONE OTHER THAN YOURSELF PLEASE ASK TO SIGN A RELEASE OF INFORMATION.

My signature below acknowledges that I am voluntarily authorizing diagnostic and treatment services for my dependent or me. I recognize that I may refuse any aspect of treatment. I also accept that such a refusal may result in termination of services. I acknowledge that I am aware that the therapist is an independent contractor, self employed, and licensed by the State of Michigan. Further, I have read this Consent and agree with the policies and procedures herein.

\_\_\_\_\_  
Signature of Patient (or Parent/Guardian)

\_\_\_\_\_  
Date

### PERMISSION AND PREFERRED METHOD OF CONTACT

**PLEASE ANSWER EACH QUESTION:**

THE OFFICE MAY LEAVE A MESSAGE AT HOME ON MY VOICE MAIL OR WITH ANY INDIVIDUAL ANSWERING MY HOME TELEPHONE  YES  NO

THE OFFICE MAY LEAVE A MESSAGE AT WORK IN MY VOICE MAIL.  YES  NO

THE OFFICE MAY MAIL TEST RESULTS OR OFFICE VISIT FOLLOW UP INFORMATION TO MY HOME ADDRESS OR ADDRESS PROVIDED.  YES  NO

**PLEASE GIVE US THE BEST PHONE NUMBER TO CONTACT YOU AT:**

\_\_\_\_\_  
(HOME MOBILE WORK)  
PLEASE CIRCLE ONE

\_\_\_\_\_  
(HOME MOBILE WORK)  
PLEASE CIRCLE ONE

\_\_\_\_\_  
(HOME MOBILE WORK)  
PLEASE CIRLE ONE

What is your preferred method for us to contact you? (Circle one) HOME WORK MOBILE

**PAGE 3 (CONTINUE TO PAGE 4)**

## PAYMENT OF FEES

Every day new insurance companies are forming and present companies are changing. Consequently, it is impossible for us to know exactly what your insurance company will cover. You should check with your insurance carrier regarding Outpatient Mental Health benefits so you are aware of your coverage regarding office visits, psychological testing, etc. It is to your benefit to be well informed so to prevent having to pay for a service that may have been covered if you had a referral, prior authorization, etc. We will make every effort to verify your benefits with your insurance company. However, this is not a guarantee of payment. Your insurance company needs to view the actual claim with diagnosis and procedure codes before making any payment decisions. If at any time your insurance company believes they paid us in error and requests reimbursement/recovery from this office you will be responsible for all these fees.

- You are responsible for all co-pays and deductibles. It is against insurance policy to ignore them.**
- Fees for services are due at the time of service unless other arrangements have been made.**
- If maximum insurance benefits have been reached, you will be responsible for any fees for services subsequently rendered.**
- Educational testing, transcription fees and other miscellaneous fees are not covered by your insurance carrier. These services are not billed to any third party carrier (insurance company) and will be your responsibility.**
- For those insurance companies requiring authorization and you fail to obtain a referral (when required) or prior authorization (when required), you will be responsible for the service rendered.**
- If you do not inform us of any insurance changes, you will be responsible for the services rendered.**
- If you do not inform us of all insurance policies, you will be responsible for the services rendered.**
- If your insurance plan does not cover services that are rendered, you will be responsible for those services**
- There is a \$25 charge for all returned checks (NSF)**

### PRIVATE PAY PATIENTS AND/OR THOSE WITHOUT INSURANCE:

- If you do not have insurance you are responsible for the fees.**
- Fees for services are due at time of service unless other arrangements have been made.**

I have read and completed the requested information to the best of my knowledge and ability and understand that I am the financially responsible party for the named patient. The signature is that of the person completing this form. For minor children, the individual bringing the child to this office is considered the financially responsible party.

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date

IF YOU ARE REQUESTING THAT WE BILL YOUR INSURANCE(S) PLEASE COMPLETE AND SIGN BELOW:

***ASSIGNMENT AND RELEASE FOR PRIMARY INSURANCE***

I, THE UNDERSIGNED CERTIFY THAT I (OR MY DEPENDENT) HAVE INSURANCE COVERAGE WITH \_\_\_\_\_ AND ASSIGN DIRECTLY TO DR. \_\_\_\_\_ ALL INSURANCE BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I HEREBY AUTHORIZE THE DOCTOR TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS.

***ASSIGNMENT AND RELEASE FOR SECONDARY INSURANCE***

I, THE UNDERSIGNED CERTIFY THAT I (OR MY DEPENDENT) HAVE INSURANCE COVERAGE WITH \_\_\_\_\_ AND ASSIGN DIRECTLY TO DR. \_\_\_\_\_ ALL INSURANCE BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I HEREBY AUTHORIZE THE DOCTOR TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS.

\_\_\_\_\_  
SUBSCRIBER/CUSTODIAL PARENT/GUARDIAN

\_\_\_\_\_  
RELATIONSHIP

\_\_\_\_\_  
DATE

**PAGE 5 (LAST PAGE)**

### SOCIAL/MEDICAL QUESTIONNAIRE - ADULTS

Patient \_\_\_\_\_ Date \_\_\_\_\_

Date of Birth \_\_\_/\_\_\_/\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Briefly, why are you seeking treatment at this time?

\_\_\_\_\_

Who referred you to our office? \_\_\_\_\_

If this is a professional who referred you, do you give consent that we may acknowledge to this person/office that we have seen you? \_\_\_ Yes \_\_\_ No

#### FAMILY HISTORY

Place of Birth \_\_\_\_\_ No. of Siblings \_\_\_\_\_ Your No. In Family \_\_\_\_\_ Parents' Marital Status Now \_\_\_\_\_

What is your race? \_\_\_ Black \_\_\_ White \_\_\_ Native American \_\_\_ Hispanic \_\_\_ Asian Other (specify) \_\_\_\_\_

Father's Education \_\_\_\_\_ Occupation \_\_\_\_\_ Age \_\_\_\_\_ If Deceased, give year \_\_\_\_\_

Mother's Education \_\_\_\_\_ Occupation \_\_\_\_\_ Age \_\_\_\_\_ If Deceased, give year \_\_\_\_\_

Did your Father work while you grew up? \_\_\_ Yes \_\_\_ No Did your Mother work while you grew up? \_\_\_ Yes \_\_\_ No

While growing up, were your parents: \_\_\_ Single \_\_\_ Married \_\_\_ Separated \_\_\_ Divorced

If Separated/Divorced, how old were you at the time? \_\_\_\_\_

With whom did you live while you were growing up? \_\_\_\_\_

Describe your relationship with your:

Father \_\_\_\_\_

\_\_\_\_\_

Mother \_\_\_\_\_

\_\_\_\_\_

Siblings (please list name and age of each sibling) \_\_\_\_\_

\_\_\_\_\_

If any brother/sister is deceased, give name, cause and age of death \_\_\_\_\_

\_\_\_\_\_

Have you ever been physically or sexually abused (circle which one)? \_\_\_ No \_\_\_ Yes \_\_\_ Don't know  
If "Yes," when and by whom? \_\_\_\_\_

Have you ever physically or sexually abused anyone (circle which one)? \_\_\_ No \_\_\_ Yes  
If "Yes," when and who? \_\_\_\_\_

Have your parents or any other family members had any mental health or alcohol/other drug problems? \_\_\_ No \_\_\_ Yes  
If "Yes," describe who and what: \_\_\_\_\_

**ADULT/MARITAL HISTORY**

Your current marital status: \_\_\_ Single \_\_\_ Married \_\_\_ Divorced \_\_\_ Widowed  
\_\_\_ Separated \_\_\_ Unmarried, Living with Significant Other

If female, your maiden name: \_\_\_\_\_

Your first marriage \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Age Date No. of Children If divorced, give date

Your second marriage \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Age Date No. of Children If divorced, give date

Any additional marital information: \_\_\_\_\_

List the names and ages of your children:

<u>Name of Child</u>	<u>Age</u>	<u>With Whom Child Lives</u>	<u>Quality of your Relationship</u>	<u>Problems</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

With whom do you currently live? Name \_\_\_\_\_ Relationship \_\_\_\_\_

Do you consider yourself to be? \_\_\_ Heterosexual \_\_\_ Homosexual \_\_\_ Bi-Sexual \_\_\_ Other

Check the best description of your relationship with your present significant other:

\_\_\_ Excellent \_\_\_ Good \_\_\_ Fair \_\_\_ Poor

Conflicts are over: \_\_\_ money \_\_\_ mental health problems \_\_\_ communication  
\_\_\_ friends \_\_\_ alcohol/other drug use \_\_\_ in-laws  
\_\_\_ job \_\_\_ legal problems \_\_\_ sex  
\_\_\_ other(s)-describe: \_\_\_\_\_

Any additional information: \_\_\_\_\_

**EDUCATION**

What is the highest grade you completed? \_\_\_\_\_ Grade \_\_\_ G.E.D. \_\_\_ Some College \_\_\_ College Degree \_\_\_ Graduate Degree

Last school attended \_\_\_\_\_

List any specialized vocational training you have: \_\_\_\_\_

Are you satisfied with your education? \_\_\_ Yes \_\_\_ No If "no," why not?" \_\_\_\_\_

**VOCATIONAL**

Are you currently employed? \_\_\_ Yes \_\_\_ No If employed, how long in this job? \_\_\_\_\_

Type of Work \_\_\_\_\_ Are you satisfied with your job? \_\_\_\_\_

What jobs have you held in the past?

<u>Job</u>	<u>Length of Time</u>	<u>Reason for Leaving</u>	<u>Job Satisfaction</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**MILITARY SERVICE**

Served in the armed forces? \_\_\_ No \_\_\_ Yes Years: \_\_\_\_\_ Branch: \_\_\_\_\_

Duty \_\_\_\_\_ Highest Rank \_\_\_\_\_ Honorable Discharge? \_\_\_ Yes \_\_\_ No

**SOCIAL RELATIONSHIPS**

Describe your friendships: \_\_\_ I have no friends \_\_\_ I have only acquaintances \_\_\_ I have both acquaintances and close friends

How many close friends do you have? \_\_\_\_\_

How often do you see them? \_\_\_ Daily \_\_\_ Frequently \_\_\_ Once in a while \_\_\_ Infrequently

**LEISURE TIME**

How do you spend most of your leisure time? \_\_\_ Alone \_\_\_ With Others \_\_\_ About Equal

List your hobbies, leisure time activities, interests and talents: \_\_\_\_\_

\_\_\_\_\_ Which do you like best? \_\_\_\_\_

What do you and your friends/acquaintances do together? \_\_\_\_\_

Have your leisure activities changed in the last two years? \_\_\_ Yes \_\_\_ No

If "Yes," explain how? \_\_\_\_\_



**FINANCES**

Do you currently have financial problems?  Yes  No  If "Yes," explain: \_\_\_\_\_

What have you done to help your financial problems? \_\_\_\_\_

**LEGAL PROBLEMS**

Have you ever been involved with the police or the courts?  Yes  No  If "Yes," specify the:

<u>Charge</u>	<u>Date</u>	<u>Outcome</u>	<u>Was this related to alcohol or other drug use?</u>

**MEDICAL/HEALTH HISTORY**

Describe your general physical health:  Good  Fair  Poor

When was your last physical exam? (month) \_\_\_\_\_ (year) \_\_\_\_\_ I can't remember the exact date, but it was approximately \_\_\_\_\_ years ago.

Reason for last physical exam \_\_\_\_\_

Name of your physician \_\_\_\_\_

Address \_\_\_\_\_

If you were referred to our office by someone other than your Primary Care Physician or you initiated treatment on your own, do we have your permission to contact your PCP and inform them of your visit/status?  Yes  No

Check all of the following physical conditions that apply to you now or in the past:

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> Thyroid Problems   | <input type="checkbox"/> Headaches                | <input type="checkbox"/> Menstrual Problems  | <input type="checkbox"/> Low Blood Sugar  |
| <input type="checkbox"/> Diabetes Mellitus  | <input type="checkbox"/> Chest Pains              | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Trouble Sleeping |
| <input type="checkbox"/> Seizures           | <input type="checkbox"/> Asthma                   | <input type="checkbox"/> Stomach Ulcers      | <input type="checkbox"/> Colitis          |
| <input type="checkbox"/> Attention Problems | <input type="checkbox"/> Other(s) (Specify) _____ |  |   |

Do you now have or have you in the past had any:

Sleep problems?  No  Yes If "yes," explain: \_\_\_\_\_

Describe your sleep generally:  Good  Fair  Poor

Allergies?  No  Yes If "yes," list them: \_\_\_\_\_

Have you ever had an allergic reaction to a food, medicine, environmental stimulus (e.g. dust, grass) drug or alcohol?  No  Yes if "Yes," to what? \_\_\_\_\_

Contagious or other diseases?  No  Yes If "yes," which? \_\_\_\_\_

Accidents/Injuries?  No  Yes If "Yes," describe? \_\_\_\_\_

Surgery?  No  Yes If "Yes," explain? \_\_\_\_\_

Do you have a Disability/Handicap?  No  Yes If "Yes," describe: \_\_\_\_\_

Check those you eat:  Meats  Fruits and Vegetables  Dairy Products  Breads

Describe your appetite:  Good  Fair  Poor  Do you eat regularly?  Yes  No

List any illnesses that run in your family: \_\_\_\_\_

Have you ever had a major illness?  No  Yes If "Yes," describe the:

Illness

Year

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever been hospitalized?  No  Yes If "Yes," explain the:

Reasons for the Hospitalizations

Year

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**EMOTIONAL HEALTH**

Have you ever had previous treatment/evaluation of emotional, learning or school-related problems?  
 Yes  No

If "Yes," was it:

Outpatient  Inpatient  Day Hospital  Substance Abuse  
 Mental Health  Psychological Testing  Psychiatric Evaluation

**Name of Center/Individual**

**Address**

**Year**

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_

Have you ever made a suicide attempt?  No  Yes If "Yes," in what year(s)? \_\_\_\_\_

Have you ever had homicidal thoughts or experienced explosive, uncontrolled anger?  No  Yes If "Yes," describe: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Have you ever engaged in purposeful self-harm (e.g. cutting, burning self, etc.)  No  Yes

If "Yes," explain: \_\_\_\_\_  
\_\_\_\_\_

Do you presently feel suicidal/homicidal (circle which)?  No  Yes If "Yes," explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**ALCOHOL/DRUG USE**

Do you currently drink alcohol/use drugs?  No  Yes If "Yes," how often? \_\_\_\_\_

Used alcohol/drugs in last 48 hours?  Yes  No If "Yes," how much? \_\_\_\_\_

Which alcohol/drug do you prefer? \_\_\_\_\_ How much usually each time? \_\_\_\_\_

List all the prescribed medications, over-the-counter drugs and street drugs you use now and have used in the past:

Prescriptions

Over-the-Counter

Street Drugs

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you use alcohol and drugs together?  No  Yes If "Yes," for how many years? \_\_\_\_\_

Do you prefer to drink and/or drug:  Alone?  With Others?

Have you ever had a bad reaction (e.g., blackout, overdose, shakes) to a prescribed, over-the-counter, or street drug, or alcohol?)  No  Yes \_\_\_\_\_ If "Yes," describe: \_\_\_\_\_

**RELIGIOUS INVOLVEMENT**

What is your religion?  Catholic  Protestant  Jewish  Muslim  Hindu  Atheist  Agnostic  
 Other (specify) \_\_\_\_\_

How active are you in your religion:  Very  Some  Minimal  None

Are you satisfied with your degree of religious involvement?  Yes  No

**ANY OTHER INFORMATION YOU WOULD LIKE TO ADD**

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Signature of Informant

Date

I have reviewed this questionnaire with the patient/informant:

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Clinician's Signature/Credentials

Date