**Siyan Clinical Corporation**
480 Tesconi Circle, Suite B, Santa Rosa, CA 95401
Tel (707)206-7268 Fax (707)206-7254

# PATIENT REGISTRATION

**DATE:**

| First Name: | Last Name: | MI: | Preferred Name: |
|---|---|---|---|
| | | | |

## Patient Information

| Address: | City: | State: | Zip: |
|---|---|---|---|
| | | | |

| Home #: Call : 1st 2nd 3rd<br>OK to leave message: ☐ Yes ☐ No | Cell #: Call : 1st 2nd 3rd<br>OK to leave message: ☐ Yes ☐ No | Work #: *Call : 1st 2nd 3rd*<br>ext:<br>OK to leave message: ☐ Yes ☐ No |
|---|---|---|
| Sex: ☐ Male ☐ Female | Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed | |

| Date of Birth: | Age: | Soc Sec #: |
|---|---|---|
| | | |

Email Address:

OK to to send appt reminders? ☐ Yes ☐ No

| Primary Care Physician's Name: | Phone #: |
|---|---|
| | |

| Address: | City: | State: | Zip: |
|---|---|---|---|
| | | | |

How did you hear about us? ☐ Website ☐ Friend ☐ Family ☐ Doctor ☐ Other
Name of whom referred you:

Occupation:

## Responsible Party (if someone other than the patient) or Parent/ Guardian (if Minor or Disabled)

| First Name: | Last Name: | Relationship: |
|---|---|---|
| | | |

| Address: | City: | State: | Zip: |
|---|---|---|---|
| | | | |

| Home #: | Cell #: | Work #:<br>ext: |
|---|---|---|
| | | |

| Date of Birth: | Soc Sec #: | |
|---|---|---|
| | | |

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

## Notify In Case of Emergency

| Name: | Relationship: |
|---|---|
| | |

| Cell #: | Home #: | |
|---|---|---|
| | | |

| Address: | City: | State: | Zip: |
|---|---|---|---|
| | | | |

By Signing below, I certify that the information on this form is true and correct:

Patient Signature ( Parent/ Guardian If Minor or Disabled)

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# Fee Schedule & Payment Agreement

Siyan Clinical Corporation is committed to providing you with the best possible care, and we welcome our patients to discuss our professional fees at any time. Our patient's clear understanding of our Fee Schedule & Payment Agreement is important to our professional relationship.

- All patients are required to complete the below forms prior to their first appointment.
  - Patient Registration
  - Fee Schedule & Payment Agreement
  - HIPAA and Privacy Form
- Co-payments and deductibles are due at the time of appointment.
- Acceptable forms of payment: cash, checks, Visa, MasterCard, American Express, Discover, and PayPal

Initial: _____

## Standard Out of Pocket Fee Schedule:

| | | |
|---|---|---|
| 1. | Initial Psychiatric Evaluation: | $250.00 (50 Minutes) |
| 2. | Suboxone Maintenance Initial Evaluation: | $300.00 (50 – 60 Minutes) |
| 3. | Medication Management: | $150.00 (20 – 45 Minutes) |
| 4. | Medication Management with Psychotherapy: | $200.00 (45 Minutes) |
| 5. | Psychotherapy by Psychologist | $125.00 (45 – 60 Minutes) |
| 6. | Urine Drug Screen | $25.00 |

*Urine Drug Screen may be required at every appointment. *

Initial: _____

## Regarding Billing and Uncollected Checks:

- Any balance not paid by the patient's insurance company within **45 days** is deemed the patient's responsibility.
- Delinquent accounts over **120 days** will be reported to a collection agency.
- Failure of payment to an overdue account or failure to communicate may result in legal action, for which the patient agrees to be held responsible for all costs and fees associated with recovery of any amounts due.
- Checks that are returned to Siyan Clinical Corporation, uncollected funds or any collection reason may be subject to an additional fee of $50.00. (Subject to change)

Initial: _____

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## Insurance:

Siyan Clinical Corporation is not authorized to change, or update patient insurance policies. Benefits are a direct contract between the patient and the insurance carrier. Any disputes of coverage are the responsibility of the patients to carry out with the insurance company. Siyan Clinical Corporation will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, "usual & customary" charges, etc. other than to supply factual information as necessary. If you have questions concerning fees for service, it is your responsibility to have these answered prior to your appointment to minimize any confusion on your behalf.
Initial: _____

## Insurance Authorization:

I authorize the release of any medical or other information necessary to process my claims. I also request payment of government or private benefits to the party who accepts assignment. This is a permanent authorization that I may revoke at any time by written notice.

Initial: _____

## My Financial Responsibility:

I understand that any balance due at the time of service is my personal financial responsibility for all services not paid for by my insurance. I am also responsible for any annual deductibles applicable, copayments, or non-covered services as may be required by my insurance plan.

Initial: _____

## Missed Appointment Fee:

Unless cancelled at least 48 hours in advance, our policy is to charge for missed appointments $50.00. Please help us to serve you better by keeping scheduled appointments. Please note on the 3rd consecutive no show you will be charge $150.00 and your case will be closed. (subject to change)

Initial: _____

## Urine Drug Screen:

A urine drug screen may take place at every visit per the providers discretion. The patient is responsible for the Standard Out of Pocket Fee if the patient's insurance does not cover the cost.

Initial: _____

**By Signing my name below, I certify that I have read the above information. Any questions concerning these policies have been discussed. My signature also certifies my understanding o the agreement with the above policies. I understand I am responsible for all charges not paid by my insurance. A photocopy of this document is as valid as the original. You may receive a copy of this document upon request.**

x_____ _____
Signature of patient or Guardian of minor/ disabled Date

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# Medication Refill Policy

*Requests for medication refills may take up to 72 hours for a response.*

**Plan Ahead:**

1. Contact us **three (3) days** before medication is due to run out, or **fourteen (14)** if you use mail order company.
2. It may take up to **three (3) business days** to refill your prescription as we must follow this process:
    a. Review your medical records.
    b. Check for expiration dates.
    c. Verify the number of refills and ensure refill eligibility.
    d. Run CURES report when appropriate.
    e. Final authorization sent to pharmacy.
3. Refill requests must be made through your pharmacy. Please have your pharmacy fax us a refill request form to 707-206-7254.
4. We utilize strict controls for controlled substance medication, and some cannot be called in to the pharmacy for refills. The patient must be seen in the office at provider's discretion for non-refillable medications to be refilled. We **WILL NOT** renew any controlled substance prescriptions if not seen face to face with the provider in our office within 30 days.
5. Refills on medications can only be authorized on medications prescribed by our providers.

x_____ _____
Signature of patient or Parent/Guardian (if Minor or Disabled) Date

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## Release of Medical Information Form

Patient Name _____ DOB _____

By my signature below, I authorize Siyan Clinical Corporation to release and / or obtain any information from my medical/ psychiatric records including diagnosis, records, examination rendered to me, progress reports, substance abuse/addiction treatment, urine drug screen results, laboratory test results and claims information. This information may be released or obtained to:

| | | |
|---|---|---|
| **Primary Care Physician:** | *Phone #:* | *Fax #:* |
| *Address:* | | |
| **Therapist:** | *Phone #:* | *Fax #:* |
| *Address:* | | |
| **Substance/Addiction Program:** | *Phone #:* | *Fax #:* |
| *Address:* | | |
| **Other:** | *Phone #:* | *Fax #:* |
| *Address:* | | |

I understand that my records are protected under the Federal regulation governing **Confidentiality of Alcohol and Drug Abuse Patent Records**, **42 CFR Part 2**, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

This Release of Information will remain in effect until terminated by me in writing.

x_____ _____

Signature of patient or Guardian of minor/ disabled Date

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## Acknowledgement of HIPAA Notice of Privacy Practices

By signing this form, I_____ consent to Siyan Clinical Corporation's to use and disclosure of my protected health information (PHI) for the following purposes:

- To provide treatment, including communication with multiple healthcare providers who may be involved in treatment directly or indirectly
- To obtain payment for services provided to you through third-party payers
- To conduct normal healthcare operations such as quality assessments, etc.

_____I have been informed I can access a copy of the HIPAA Notice of Privacy Practices on Siyan Clinical Corporation's website Siyanclinical.com or posted in the waiting room. At any time, I can ask for a copy of the HIPAA Notice of Privacy Practices (HNOPP).

_____Siyan Clinical Corporation reserves the right to change our privacy practices as described in our HNOPP. If we change our privacy practices, we will issue a revised HNOPP, which will contain the changes. Those changes may apply to any of your PHI that we maintain.

_____I understand that I have the right to revoke this consent at any provided in writing. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

_____I have had a full opportunity to read and consider the contents of this consent form and this office's NOPP. I understand that, by signing this consent, I am allowing Siyan Clinical Corporation's use and disclosure of my PHI to carry out treatment, payment activities, and healthcare operations.

_____ _____
Print Patient Name Print Guardian Name

_____ _____
Patient/ Guardian Signature Date

**OFFICE USE ONLY**

_____ Individual Refused to Sign

_____ _____
Signature of Office Supervisor Date

*Last Revised: 5/1/2018*

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## PATIENT INFORMATION

Full Name: _____ DOB: _____

Right / Left Handed WT: _____ HT: _____ Age: _____

Reason for Appointment: _____

Current Pharmacy Name: _____

Address: _____

Phone Number: _____

## HEALTH HABITS

Do you currently use any of the following (if yes, how much/how often)?

Caffeine: Select C _____ Alcohol: Select C _____

Tobacco: Select C _____ Marijuana: Select C _____

Other Illicit Drugs (Ex. Cocaine, Methamphetamine, Opiates, PCP, LSD, Etc.)? Yes / No _____

Do you ever blackout? Select One Describe: _____

Compulsive cleaning? Select One Describe: _____

Exercise regularly? Select One Describe: _____

Age of first sexual activity: _____ Pleasant? Select One Coerced or consensual?

## PSYCHIATRIC HISTORY

Have you ever been committed to a psychiatric hospital? Select One Select One

For what reason? _____ How long? _____ Did it help? Select One

Have you ever gone through an Inpatient Rehab program? Select One When? _____

Have you ever been in long term therapy? Select One How long? _____

Name of therapist/psychiatrist/psychologist: _____

## MEDICAL CONDITIONS

Any ongoing conditions: Select One

Please list all ongoing conditions (i.e.; hypothyroid, hypotension, etc.): _____

_____

_____

Allergies to Medications? Select One

If Yes: Please list medication and symptoms (i.e.; rash, swelling, hives, etc.): _____

_____

## MEDICATIONS (CURRENT & PAST)

**Current List of Psychiatric Medications (please list on back if more room needed):**

| Name of Medication | Dosage | Frequency | Diagnosis | How Long? | Side Effects (if any) |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**Past Psychiatric Medications:**

| Name of Medication | Dosage | Frequency | Diagnosis | How Long? | Side Effects (if any) |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**Current list of PAIN or ANY other Medications:**

| Name of Medication | Dosage | Frequency | Diagnosis | How Long? | Side Effects (if any) |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

## History of Psychiatric Disorder (Family/Self)

Any of these conditions or family history of them? Please check any that apply and whom it affects (self, mother, etc.):

| | Condition | Self/Relative (specify) | | Condition | Self/Relative (specify) |
|---|---|---|---|---|---|
| | Learning Disability | | | Dementia | |
| | ADHD | | | Schizophrenia | |
| | Bipolar | | | Depression | |
| **Anxiety Disorder(s) such as:** | | | | Other (Please Specify) | |
| | OCD | | | Other (Please Specify) | |
| | Panic Attacks | | | Other (Please Specify) | |
| | Post-Traumatic Stress | | | Other (Please Specify) | |
| | Generalized Anxiety | | | Other (Please Specify) | |

**Past Psychiatric Care:**

| Reason | Dates | Type of Treatment/Test | Provider | Hospitalization? |
|---|---|---|---|---|
| | | | | |
| | | | | |

| TYPES OF TREATMENT (circle applicable) | Y/N | | HOW HELPFUL WAS TREATMENT | | |
|---|---|---|---|---|---|
| Acupuncture: | ☐ Yes | ☐ No | ☐ No Help | ☐ Good | ☐ Very Helpful |
| Physical Therapy: | ☐ Yes | ☐ No | ☐ No Help | ☐ Good | ☐ Very Helpful |
| Chiropractic: | ☐ Yes | ☐ No | ☐ No Help | ☐ Good | ☐ Very Helpful |
| Injections: | ☐ Yes | ☐ No | ☐ No Help | ☐ Good | ☐ Very Helpful |
| Type: | ☐ Epidural | ☐ Cortisone | ☐ No Help | ☐ Good | ☐ Very Helpful |

Surgery: Select One If yes, list body part(s) and Date: _____

MRI: Select One If yes, list body part(s) and Date: _____

EMG: Select One If yes, list Date: _____

Do you have any of the following (please circle yes or no):

Tuberculosis ☐ Yes ☐ No Hepatitis ☐ Yes ☐ No High Cholesterol ☐ Yes ☐ No

HIV ☐ Yes ☐ No Diabetes ☐ Yes ☐ No

Heart Disease ☐ Yes ☐ No High Blood Pressure ☐ Yes ☐ No

Other serious illnesses: _____

**Women's Gynecologic History**

#of Pregnancies: ____ # of Births: _____ # of C-Section Deliveries _____ # of Abortions: _____

1st day of last period: _____ Age of 1st period: _____ Frequency: _____ Duration: _____

Do you have any concerns about your periods? Select One Concerns about menopause? Select One

**Abuse History**

Are/Were you a victim of any of the following abuses?

Physical Abuse: Select One Age(s) of occurrence: _____

Sexual Abuse: Select One Age(s) of occurrence: _____

Emotional Abuse: Select One Age(s) of occurrence: _____

## SOCIAL HISTORY

Where were you born? _____ Where did you grow up? _____

Siblings: ___# of Brothers __# of Sisters

Have any siblings died? Select One When? _____ Are living siblings in good health? Select One

Were there any complications at your birth (premature, major medical problems)? Select One

If yes, please describe: _____

Were there any problems in your early development (learning to walk, talk, etc.)? Select One

If yes, please describe: _____

Did you suffer from any major illnesses/injuries while growing up? Select One

If yes, please describe: _____

Are you currently involved in a romantic relationship? Select One

Spouse/Partner's first name? _____ How long have you been together? _____

How would you describe your relationship? _____ Is spouse healthy? Select One

Do you feel you have a strong support system (family/friends)? Select One Do you have children? Select One

What are their names and ages? _____

Any children ever seriously ill or hospitalized? Select One Are they healthy now? Select One

Children ever been suspended/expelled? Select One Any legal troubles? Select One

Is there any family history of (circle all that apply)? Drug Abuse / Arrests / Gang Activity / Domestic Violence / Suicide Attempts / Overdose / Legal Problems / Lawsuits / Gambling Addiction / Sex Addiction / Other (please describe if other): _____

Please describe interests (*hobbies, sports, pastimes*): _____

## LEGAL HISTORY

Prior Workers' Comp Claims? Select On Findings: _____

Any other lawsuits? Select On Describe: _____

Ever been sued? Select One Ever filed bankruptcy? Select One Ever been evicted? Select One

Ever been arrested? Select One What charges? _____

Ever been convicted? Select One Ever serve prison/jail time? Select One

Where/how long? _____

Ever been a victim of a crime? Select On Describe: _____

Ever been the victim or aggressor of domestic violence? Select On Describe: _____

Ever lost custody of children? Select Or When? _____ Family or child services involved? Select One

Other (please specify): _____

## Problem Inventory

I am currently experiencing the following problems (check all that apply)

- ☐ Relationship problems
- ☐ Problems on the job
- ☐ Losing someone close to you
- ☐ Problems with my children

- ☐ Feeling guilty about past mistakes
- ☐ Feeling that I am no good
- ☐ Feeling the need to get more sleep
- ☐ Losing pleasure in daily activities
- ☐ Often feeling restless and irritable
- ☐ Often feeling sluggish, low energy, or foggy
- ☐ Thoughts about dying or killing myself
- ☐ Trouble keeping my mind on a task
- ☐ Feeling sad

- ☐ Preoccupied with sexual thoughts/urges
- ☐ Needing less sleep than usual and not feeling tired
- ☐ Spending sprees
- ☐ Trouble making myself slow down or talk less
- ☐ Inflated self-esteem or grandiosity
- ☐ Feeling like my thoughts are racing in my head
- ☐ Easily distracted

- ☐ Fear of crowds or public places,
- ☐ Specific fear of a thing or place,
- ☐ Attacks of fearfulness when I feel I need to run,
- ☐ Heart palpitations,
- ☐ Chest pains/discomfort, feeling dizzy or unsteady,
- ☐ Feeling things that aren't there,
- ☐ Tingling in hands or feet,
- ☐ Hot or cold flashes,
- ☐ Trouble breathing,
- ☐ Feeling shaky or trembling,
- ☐ Fears of dying or going crazy,
- ☐ Feeling the urge to avoid certain places/objects,
- ☐ Feeling troubled by repetitive thoughts,
- ☐ Feeling anxious and nervous,
- ☐ Worrying about things over and over,

- ☐ Feeling the urge to do something unnecessary,
- ☐ Checking, hand washing, hair pulling,

- ☐ People following me, out to hurt me, talking about me,
- ☐ People reading my thoughts,
- ☐ Hearing voices,
- ☐ Thoughts being put into my head, controlling me, making me do things,
- ☐ Special messages to me from TV or radio,

- ☐ Feeling emotionally numb,
- ☐ Recurring nightmares,
- ☐ Frequently feeling startled,
- ☐ Being troubled by painful memories,
- ☐
- ☐ Parts of my body not functioning well,
- ☐ Feeling aches and pains all over my body,
- ☐ Often feeling sickly,
- ☐ Fear of having or getting a disease
- ☐ Problems with my memory,
- ☐ Knowing where or who I am,
- ☐ Getting lost or confused,
- ☐ Having trouble remembering my past,
- ☐ Finding things,
- ☐ Feeling that I've lost time,

- ☐ Urges to do something harmful to myself,
- ☐ Urges to set fires,
- ☐ Difficulty controlling my temper,
- ☐ Feeling anger or resentment,

- ☐ Taking laxatives to control my weight,
- ☐ Vomiting to control my caloric intake,
- ☐ Exercising frequently and vigorously,
- ☐ Fasting in order to control my weight,
- ☐ Feeling helpless about my eating habits,
- ☐ Extreme changes in my weight.

**By signing below, I certify that the information on this form is true and correct:**

**Signature:** _____ **Date:** _____

Print name: _____

NAME: _____ Date:_____

# *Siyan Clinical Corporation*

## PATIENT HEALTH QUESTIONAIRE - 9
## (PHQ-9)

| **Over the last 2 weeks, how often have you been bothered by any of the following problems?** | **Not at all 0** | **Several Days 1** | **More than half the days 2** | **Nearly every day 3** |
|---|---|---|---|---|
| **1.** Little interest or pleasure in doing things | ○ | ○ | ○ | ○ |
| **2**. Feeling down, depressed, or hopeless | ○ | ○ | ○ | ○ |
| **3.** Trouble falling or staying asleep, or sleeping too much | ○ | ○ | ○ | ○ |
| **4.** Feeling tired or having little energy | ○ | ○ | ○ | ○ |
| **5**. Poor appetite or overeating | ○ | ○ | ○ | ○ |
| **6.** Feeling bad about yourself - or that you are a failure or have let yourself or your family down | ○ | ○ | ○ | ○ |
| **7.** Trouble concentrating on things, such as reading the newspaper or watching television | ○ | ○ | ○ | ○ |
| **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 | ○ | ○ | ○ | ○ |
| **9.** Thoughts that you would be better off dead or of hurting yourself in some way | ○ | ○ | ○ | ○ |

**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 |
|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ |

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# Consent Form

## Patient Text Message, E Mail, and Automated Phone Calls

Full Name: _____

Date of Birth: _____

Address: _____

_____

Mobile Phone: _____

Email Address: _____

1. I consent to Siyan contacting me by text message, email, and automated phone calls for the purpose of receiving appointment reminders.
2. I acknowledge that appointment reminders by text, email, and automated phone calls are an additional service and that these may not take place on all occasions and that the responsibility of attending appointments or cancelling them still rests with me. I understand that if I am not able to keep an appointment, I will phone the office to cancel.
3. Text messages, email, and automated phone calls are generated using a secure facility, but I understand that they are transmitted over a public network onto a personal telephone and as such may not be secure.
4. All patients have the right to discontinue these services and must notify front office reception.
5. I agree to advise Siyan if my mobile number changes or if this is no longer in my possession.

Signed _____

Date _____

PRACTICE USE ONLY: FORWARD FOR SCANNING ☐

PATIENT CONSENT FORM COMPLETED ☐ STAFF INITIALS _____