TIMOTHY A ROGGE MD ELIZABETH L ROGGE MS ARNP
FAMILY MEDICAL PSYCHIATRY
8105 166TH AVE NE SUITE 202 REDMOND WA 98052
HTTP://FAMILYMEDPSYCHIATRY.COM/
OFFICE LINE 425-647-1225 FAX 425-861-1085

NEW PATIENT REGISTRATION DOCUMENTS

PATIENT INFORMATION

PATIENT NAME: _____.DOB:_____. M:___. F:___.NONBINARY___.

PARENT/GUARDIAN NAME:_____.

HOME ADDRESS:_____.

CITY/STATE/ZIP:_____.

PRIMARY PHONE:_____. ALTERNATE PHONES:_____.

PLEASE CHECK IF WE MAY SEND APPT INFO VIA TEXT MSG___ON VOICE MAIL___OR LEAVE WITH FAMILY MEMBERS___.

SPOUSE OR EMERGENCY CONTACT:_____. PHONE:_____.

REFERRED BY:_____. PHONE:_____.

PRIMARY CARE PHYSICIAN:_____. PHONE:_____.

OTHER PROVIDER ONE:_____. PHONE:_____.

OTHER PROVIDER TWO:_____. PHONE:_____.

FINANCIAL INFORMATION

DO YOU WISH US TO BILL INSURANCE? YES:_____. NO:_____.

PRIMARY INSURANCE COMPANY:_____.

GROUP/POLICY NUMBER:_____.

POLICYHOLDER: _____ DOB: _____M: ___ F: ___

POLICYHOLDER'S EMPLOYER_____

INSURANCE COMPANY:_____. ID#_____ GROUP/POLICY NUMBER:_____.

SECONDARY INSURANCE COMPANY:_____.

GROUP/POLICY NUMBER:_____.

POLICYHOLDER: _____ DOB: _____M: ___ F: ___

POLICYHOLDER'S EMPLOYER_____

INSURANCE COMPANY:_____. ID#_____

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TERMS OF PAYMENT

INSURANCE: You are responsible for payment for services. As a courtesy to you, we will bill your insurance company. If your insurance company declines to pay your claim, you are responsible for payment of your account in full. If your insurance company require pre-certification or pre-authorization for your treatment, it is your responsibility to make sure that such authorization is in place. If you have a copay, it is due to be paid at the time of service.

DELINQUENT ACCOUNTS: Contact the office to create a payment plan, if necessary. Your account balance will be sent to collections if payment is not rece9ived and we do not hear from you. No appointments can be set until overdue balances are addressed.

MISSED APPOINTMENTS: To avoid the $50 missed appointment fee, contact the office at **425-647-1225** at least 24 hours before the scheduled appointment. Missed initial appointments will not be rescheduled.

I AUTHORIZE TIMOTHY A ROGGE MD AND ELIZABETH L ROGGE MS ARNP TO RELEASE ANY INFORMATION NECESSARY TO MY INSURANCE COMPANY TO EXPEDITE HEALTH INSURANCE CLAIMS. I HEREBY ASSIGN ALL HEALTH INSURANCE BENEFITS TO TIMOTHY A ROGGE MD OR ELIZABETH L ROGGE MS ARNP. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES, REGARDLESS OF INSURANCE COVERAGE.

PERSON FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT:_____.

SIGNATURE OF PERSON RESPONSIBLE FOR PAYMENT:_____.

RELATIONSHIP TO PATIENT:_____. PHONE:_____.

ADDRESS:_____.

CITY/STATE/ZIP:_____.

RESPONSIBLE PARTY'S EMPLOYER:_____. PHONE:_____.

I HAVE READ AND UNDERSTAND THE ABOVE TERMS OF PAYMENT,

PATIENT NAME, SIGNATURE, DATE:_____.

PARENT/GUARDIAN NAME, SIGNATURE, DATE:_____.

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CONSENT FOR TREATMENT

I authorize and request TIMOTHY A ROGGE MD OR ELIZABETH L ROGGE MS ARNP to provide treatment and diagnostic procedures as they become advisable. I understand the purpose of these procedures will be explained and that they are subject to my agreement. I understand that while my treatment is designed to help, no guarantees about outcome are made. THIS AUTHORIZATION CONSTITUTES INFORMED CONSENT WITHOUT EXCEPTION.

PATIENT NAME, SIGNATURE, DATE:_____.

PARENT/GUARDIAN NAME, SIGNATURE, DATE:_____.

SERVICES OFFERED: All initial appointments are considered consultations and do not constitute agreement to treat the patient. Our services only include consultation and treatment. We do not perform written or verbal evaluations or provide reports for non-health care third-party organizations such as courts, attorneys, disability insurance companies, employers, etc.

PRESCRIPTION REFILLS: It is your responsibility to keep track of your medication supply. If your supply will not last, ask your pharmacy to fax us a refill request at least 3 business days before you run out. Do not leave refill requests on the office line or your provider's phone line. We do not refill medication unless there is a future appointment on the calendar. In general prescriptions for controlled medications are issued only at an appointment and will not be refilled before next refill due date regardless of reason (misplaced, lost, stolen, used more than prescribed).

APPOINTMENTS SCHEDULING: All appointment scheduling or changes made by phone must be done through the office line, **425-647-1225**. Do not leave appointment requests on your provider's phone line.

LIMITS OF CONFIDENTIALITY

Contents of a visit are confidential. Verbal information and written records about a patient cannot be shared with another party without the written consent of the patient or the patient's legal guardian. EXCEPTIONS ARE AS FOLLOWS:

COORDINATION OF CARE: To support comprehensive care coordination and prevent unintentional adverse treatment combinations, records will be shared with other providers involved in the care of a patient. If this is not allowed, we will refrain from sharing the initial consultation summary but will not be able to provide ongoing care.

DUTY TO WARN AND PROTECT: When a patient discloses intentions or a plan to harm another person, the health care professional is required to warm the intended victim and report this information to legal authorities. In cases in which the patient discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the patient.

ABUSE OF CHILDREN AND VULNERABLE ADULTS: If a patient states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the health care professional is required to report this information to the appropriate social service and/or legal authorities.

PRENATAL EXPOSURE TO CONTROLLED SUBSTANCES: Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

COURT ORDERS: Health care professionals are required to release records of clients when a court order has been placed. Without a court order, there is no legal obligation to release records.

OTHER PROVISIONS: When fees for services provided are not paid in a timely manner, collection agencies may be utilized in collection of unpaid debts. The specific content of the services (E.G. diagnosis, treatment plan, case notes, testing) is not disclosed. IF a debt remains unpaid it may be reported to credit agencies, and the client's credit report may state the amount owed, time frame, and the name of the clinic.

Your health insurance company is given information that they request regarding services to clients. Information which may include type of services, dates/times of services, diagnosis, treatment plan, description of impairment, progress of therapy, case notes and summaries.

To protect your privacy, calls from family or friends will not be returned unless there is release of information signed by you authorizing us to talk with them. It is more useful for them to come with you for an appointment if they have questions or concerns.

I HAVE READ AND UNDERSTOOD THE ABOVE LIMITS OF CONFIDENTIALITY AND SERVICES OFFERED,
PATIENT NAME, SIGNATURE, DATE:_____.

PARENT/GUARDIAN NAME, SIGNATURE, DATE:_____.

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NOTICE OF PRIVACY PRACTICES

WE KEEP A RECORD OF THE HEALTH CARE SERVICES WE PROVIDE TO YOU. WE WILL NOT DISCLOSE YOUR RECORD TO OTHERS UNLESS YOU DIRECT US TO DO SO OR UNLESS THE LAW AUTHORIZES OR COMPELS US TO DO SO.

I AUTHORIZE TIMOTHY A ROGGE MD OR ELIZABETH ROGGE MS ARNP TO DISCLOSE MY RECORDS AND CONTENTS TO:

NAME AND RELATIONSHIP:_____.

NAME AND RELATIONSHIP:_____.

NAME AND RELATIONSHIP:_____.

ARE THERE ANY MEMBERS OF YOUR HOUSEHOLD WITH WHOM WE SHOULD NOT DISCUSS ANY OF YOUR HEALTH CARE ISSUES?
NO__ (IF YES, PLEASE LIST BELOW)

NAME AND RELATIONSHIP:_____.

NAME AND RELATIONSHIP:_____.

NAME AND RELATIONSHIP:_____.

I HAVE READ AND UNDERSTOOD THE ABOVE NOTICE OF PRIVACY PRACTICES,

PATIENT NAME, SIGNATURE, DATE:_____.

PARENT/GUARDIAN NAME, SIGNATURE, DATE:_____.

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PSYCHIATRIC AND GENERAL HEALTH QUESTIONNAIRE

PROBLEMS FOR WHICH YOU WANT HELP: BRIEF LIST.

ALL CURRENT HEALTHCARE PROVIDERS: NAME, ADDRESS, PHONE, FAX.

ALL CURRENT MEDICATIONS: PSYCHIATRIC MEDICATIONS, MEDICATIONS TAKEN FOR OTHER CONDITIONS, SUPPLEMENTS. INCLUDE DOSAGE AND TIMES TAKEN.

MEDICATION REACTIONS: ALLERGIES (RASH, SWELLING, HIVES, DIFFICULTY BREATHING) AND ANY OTHER NEGATIVE REACTIONS.

MEDICAL HISTORY: **1)** ALL DIAGNOSED ACTIVE MEDICAL PROBLEMS, WITH TREATING PHYSICIAN AND CURRENT TREATMENT. **2)** HISTORY OF INFECTIOUS DISEASE (TUBERCULOSIS, MRSA, SEXUALLY TRANSMITTED DISEASES ETC). **3)** PAIN. **4)** SERIOUS INJURIES, MAJOR SURGERIES, MEDICAL OR SURGICAL HOSPITALIZATIONS (WITH APPROXIMATE DATES). **5)** SEXUAL HISTORY (SEXUAL FUNCTION, PREGNANCIES, BIRTHS, MISCARRIAGES, TERMINATIONS).

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IMMUNIZATIONS: NOTE APPROXIMATE DATES
CHILDHOOD VACCINATIONS _____. TETANUS_____, WHOOPING COUGH_____. HPV _____, INFLUENZA_____, PNEUMONIA _____. SHINGLES _____. OTHERS (LIST BELOW)

HEALTH MAINTENANCE:

HEIGHT _____ WEIGHT _____. **1)** SIGNIFICANT WEIGHT CHANGES AND REASONS. **2)** HISTORY OF WEIGHT LOSS SURGERY. **3)** HISTORY OF EATING DISORDER.

EXERCISE: CURRENT TYPE AND FREQUENCY, PAST FITNESS AND ATHLETIC HISTORY.

NUTRITION: REGULAR DIET, DIABETIC DIET, COUNTING CALORIES, ANY RESTRICTIONS, ETC.

SLEEP: 1) YOUR OWN PAST NORMAL TIMES TO FALL ASLEEP AND AWAKEN WITHOUT OBLIGATION OR SCHEDULE. **2)** CURRENT WORK SHIFT. **3)** CURRENT PATTERN WITH AND WITHOUT MEDICATION. **4)** KNOWN OR SUSPECTED SLEEP DISORDER (SLEEP APNEA, RESTLESS LEGS, NIGHTMARES, ETC.), EVALUATION AND TREATMENT.

SUBSTANCE USE (AMOUNT AND FREQUENCY OF USE. MENTION DUI OR TREATMENT)**:**

DRUGS

ALCOHOL

TOBACCO

CAFFEINE:

FAMILY HISTORY: PSYCHIATRIC DISORDERS OR CHEMICAL DEPENDENCY IN BLOOD RELATIVES, ESPECIALLY CLOSE RELATIVES AND ANCESTORS.

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SOCIAL HISTORY: **1)** FAMILY OF ORIGIN (where raised, members of household, quality of home life, any abuse, occupations of parents). **2)** EDUCATION (degrees, where, when). **3)** MILITARY SERVICE (when, type of discharge). **4)** PLACES LIVED AS ADULT. **5)** LIVELIHOOD (current employment, longest employment, current sources of income and financial status, **6)** RELATIONSHIPS (marriages, committed relationships, friends, social support). **7)** CURRENT HOUSING (location, type, members of household). **8)** DAILY ROUTINE. **9)** SPARE TIME ACTIVITIES AND HOBBIES. **10)** RELIGIOUS AFFILIATION. **11)** LEGAL (arrests, convictions, incarcerations). **12)** TRAUMA (assault, natural disaster, accident, witnessed atrocity), **13)** PERSONAL GOALS. **14)** CURRENT ISSUES (recent life changes or new stresses).

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HISTORY OF PRESENT ILLNESS: 1) CURRENT SYMPTOMS WITH ONSET, COURSE AND DURATION. **2)** RECENT TREATMENT WITH RESULTS. **3)** RECENT EVENTS LEADING UP TO CONSULTATION.

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PAST AND DEVELOPMENTAL HISTORY: 1) CHILDHOOD HEALTH AND PERSONALITY.**2)** GENERAL FEELING AND FUNCTION BEFORE PROBLEMS BEGAN. **3)** FIRST OCCURRENCE OF SYMPTOMS, ONSET (SUDDEN OR GRADUAL), WITH ANY TRIGGERS. **4)** TIMELINE OF SYMPTOMS SINCE ONSET (STEADY OR RECURRING, GENERAL WORSENING OR IMPROVEMENT, CHANGE IN TYPE OF PRIMARY SYMPTOM, ADDITION OF OTHER SYMPTOMS). **5)** LIST MEDICATIONS AND OTHER TREATMENTS TRIED, WITH APPROXIMATE DATES AND RESULTS. **6)** NOTE ANY PSYCHIATRIC HOSPITALIZATIONS WITH DATES.
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