BETH SJOGREN-MILLER, APRN
REGISTRATION FORM

Today's date:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	

P.O. box:	City:	State:	ZIP Code:

Home Phone:	Cell Phone:	Work Phone:

Occupation:	Employer:	Employer phone no.: ( )

Referred by (please check one box): ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

INSURANCE INFORMATION

PLEASE FILL OUT ENTIRE SECTION

Please indicate primary insurance

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	ID no:	Group no.:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

Authorization to Release Information & Assignments of Benefits

I authorize the release of medical information necessary to process a claim. I permit a copy of this authorization to be used in the place of the original. I hereby authorize and request my insurance company to pay the amount due on my pending claim for medical care to: Andrea DiFilippo, LICSW & Associates. I agree that I will make payment within 90 days of the date of service if my insurance company has not paid, and that it is my responsibility to contact my insurance company for reimbursement. I agree to pay co-pays at the time of service.

_____ _____

Patient/Guardian signature *Date*

STATEMENT REGARDING PRIVATE HEALTH INFORMATION

NAME:

DATE:

It is the intent of this office to be in compliance with the privacy standards for Private Health Information (PHI) covered under Heath Insurance Portability and Accountability Act (HIPPA).

1. I understand that I have the right to request that certain information be excluded from my record unless the information is related to my diagnosis or is related to one of the exceptions listed on "Your Rights As A Client"
2. I understand that I have the right to amend information but not expunge (erase) information from my record.
3. I understand that I have the right to inspect and/or receive a copy of my Private Health Information (PHI) i.e. record unless it is legally determined that it would adversely affect my well-being, or I am a minor. My request must be fulfilled by this office within 60 days of my written request. There will be a charge for copies.
4. As additional HIPAA regulations are mandated and clarified, this office will be altering its policies and procedures to be in compliance.
5. If this office is found to be in violation of the Primary Standards put forth in HIPAA, I am urged to speak with my therapist and if not resolved, I have a righty to file a formal complaint with the Office of Civil Liberties.

I have read the above privacy standards for private health information covered under HIPPA.

SIGNATURE: _____
(CLIENT/GUARDIAN)

PATIENT HEALTH QUESTIONNAIRE

OVER THE LAST 2 WEEKS, HOW OFTEN HAVE YOU BEEN BOTHERED BY ANY OF THE FOLLOWING PROBLEMS?	**NOT AT ALL**	**SEVERAL DAYS**	**MORE THAN HALF THE DAYS**	**NEARLY EVERY DAY**
Little interest or please in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling or staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
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	0	1	2	3
Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING _____ + _____ + _____ + _____

TOTAL SCORE = _____

If you circled higher than 0 on 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
○	○	○	○

1. Have you or any of your blood relatives recently developed a new illness or have you learned new information about your family medical psych history? No ___ Yes ___ (please list below)

   _____

   _____

2. Have you developed any drug allergies or stopped/started/changed any medications or supplements? No ___ Yes ___ (Please list below)

   _____

   _____

3. What do you do for exercise? How long? How often?

   _____

   _____

4. How much tobacco do you smoke or chew per day? _____

5. How much alcohol do you drink per day _____? Total in a week? _____ (1 drink+ 12 oz beer = 4 or 5 oz wine = 1oz spirits)

6. How much caffeine (coffee, tea, energy drinks, soda) do you consume daily? _____ Latest time in the day? _____
7. Do you use any other substances? (i.e. marijuana, ecstasy, cocaine, methamphetamine, opiates, etc) How much? How often?

   _____

8. Do you own or have access to firearms? No ____ Yes ____

Notes by ARNP only below this line:

Ht ____

Wt ____ lbs

BP ____ sit ____ stand

P ____ sit ____ stand