BROOKE WEINGARDEN, DO MPH, PLLC

Birmingham Maple clinic Date: _____

PATIENT INFORMATION FOR ADULT:

Patient Name:	Date of Birth	SSN:
Address:		
City, State, Zip:		
Telephone: Home: ( )	Work: ( )	Cell: ( )
Email:	You may contact me by email Yes □ No □	
Employer:		
Employer Address:		
City, State, Zip:		
School:		
Person responsible for payment if other than patient: Name: _____ Address: _____ _____	Telephone: Home: _____ Work: _____ Cell: _____	
Subscriber Information: **Primary Insurance** :		
Group number:	Subscriber SS #:	Subscriber birthdate:
Subscriber Name:		Relationship:
Insurance Co. Phone:		
Secondary Insurance:		
Group #:	Subscriber SS#:	Subscriber birthdate:
Subscriber name:		Relationship:
Insurance Co. Address		
Insurance Co. Phone		
Private Pay:		

Patient Name: _____

Primary care physician:

Name: _____

Address: _____ City: _____ State_____Zip_____

Phone:_____Date of last physical exam:_____

Referring Physician: □ Is my primary care physician

Name: _____

Address: _____ City: _____ State_____Zip_____

Phone: _____

_____

Emergency Contact Name: _____ Relationship to Patient: _____

Emergency Contact Phone Number: _____

PHARMACY

We are now able to transmit your prescriptions electronically. Please list your pharmacy information below:

Local Pharmacy: _____ Phone Number: _____

Address (or cross streets): _____ City: _____

Mail Order Pharmacy: _____ Phone Number: _____

Address: _____City_____State_____Zip code_____

BROOKE WEINGARDEN, DO, MPH, PLLC

FINANCIAL POLICY

As a patient of Dr. Weingarden, it is important for you to understand the following information:

* You are responsible for the timely payment of your account. Your co-pay amount should be paid at each session

* We accept cash, check, Visa and MasterCard

* Payment should be made by the parent/guardian who brings their child to the appointment. We will not become involved in disputes between individuals. It is your responsibility to assure that we receive payment for the services rendered. After the 1st visit, co-payments should be made at the time of each appointment.

***Missed appointments:** My staff will try to call you to remind you prior to each appointment. Unless canceled 24 hours in advanced, my policy is to charge for missed appointments. Keep in mind that insurance companies will not cover this cost. Please help us serve you better by keeping all scheduled appointments.

***Insurance:** We will verify your insurance following the first visit. Verification of coverage does not guarantee payment. Insurance is a contract between you and your insurance company. We cannot be a party to this contract. In most cases, we file insurance claims as a courtesy to our patients. Although we will supply factual information to your insurance company when necessary, we will not become involved in disputes between you and the company regarding deductibles, co-payments, covered charges, secondary insurance coverage, usual and customary charges etc. In the event that third party payment is denied after the service has been provided, you will still be held responsible for the cost of that service.

THANK YOU FOR UNDERSTANDING OUR FINANCIAL AND INSURANCE POLICIES. PLEASE LET US KNOW IF YOU HAVE ANY QUESTIONS OR CONCERNS.

_____ _____

Patient, Parent or Guardian (if under 18) Date Witness Date

_____

Social Security Number

PERSON RESPONSIBLE FOR PAYMENT IF OTHER THAN PATIENT:

Name: _____ Telephone: _____

Address: _____

Employer: _____ Telephone: _____

Employer's Address: _____

Signature of Responsible Party: _____

BROOKE WEINGARDEN, DO, MPH, PLLC

STATEMENT OF FINANCIAL RESPONSIBILITY

I assume financial responsibility for all scheduled appointments attended and for those not attended unless cancellation is made prior to twenty-four hours of the scheduled appointment time.

Patient, Parent or Guardian

Witness

Date

Date

AUTHORIZATION TO PAY BENEFITS TO PROVIDER

I hereby authorize payment directly to the provider of the Benefits, if any, otherwise payable to me for the services rendered. I understand the provider's charge may exceed the private insurance carrier payment. If the charge is greater than such payment; I will be responsible for that amount. I hereby authorize the provider to release any information required in order to obtain these Benefits.

Patient, Parent or Guardian

Witness

Date

Date

BROOKE WEINGARDEN, DO, MPH, PLLC

INFORMED CONSENT

My Treatment plan has been reviewed with me and I have had the opportunity to discuss any questions with Dr. Weingarden.

_____	_____
Patient, Parent or Guardian	Witness
_____	_____
Date	Date

BROOKE WEINGARDEN, DO, MPH, PLLC

HEALTH/BACKGROUND INFORMATION

Name _____ DOB _____ Date _____
Sex: M F Age: _____ Ethnic Background: _____ Religious Belief: _____
Phone: _____ work: _____ Cell: _____

ALLERGIES: _____

Current prescriptions and over the counter medications:

Current concerns;

Have you threatened or attempted to harm yourself or others □ Yes □ No If yes explain:

FAMILY INFORMATION:
If any blood relative has suffered any of the following, please check the appropriate box and indicate which relative:
□ Heart Attack _____ □ Arthritis _____
□ Stroke _____ □ Glaucoma _____
□ Cancer _____ □ Hypertension _____
□ Diabetes _____ □ Allergies _____
□ Epilepsy _____ □ Alcohol/Drug problems _____
□ Lung disease _____ □ Mental / Emotional problems _____

MEDICAL HISTORY:

Primary Care Physician: _____ phone number: _____
Date of last physical: _____
Recent weight gain? _____ Loss? _____ appetite change? _____
Please provide any information on any surgical procedures and/or hospitalizations: _____

History of serious accident or injury? □No □Yes: _____

History of nutritional problems? □ No □Yes: _____

Substance use? □ No □ Yes If yes , describe: _____
Substance abuse treatment □ No □ Yes If yes, explain _____
□Tobacco □Alcohol □Marijuana □Cocaine □Heroin □Pills □inhalants □synthetic drugs □hallucinogens
□ other _____

Check all that apply:

□ seizures	□ heart murmur	□ abnormal balance
□ headaches	□ fast heartbeat	□ tremor
□ injury to head	□ irregular heartbeat	□ dizziness
□ loss of consciousness	□ chest pain	□ fainting spells
□ vision changes	□ change in appetite	□ tics / twitching
□ hearing problems	□ weight change	□ muscle weakness
□ musculoskeletal problem	□ nausea/ vomiting	□ numbness/ tingling
□ sinus problems	□ jaundice/ hepatitis	□ rashes/ hives
□ nosebleeds	□ liver disease	□ sweating
□ abnormal sense of smell	□diabetes	□ bone fractures
□ sore mouth or tongue	□ abdominal pain	□ joint pain
□ dental problems	□ constipation/ diarrhea	□ cancer/ tumor
□ difficulty with speech	□ urinary infections	□ anemia
□ frequent sore throats	□ frequent urination	□ bleeding/ bruising
□ thyroid problems	□ blood in urine	□ chronic fatigue
□ breathing problems	□ kidney disease	□ frequent infections
□ shortness of breath	□ sexual problems	□ scarlet fever
□ Asthma/Wheezing	□ Gynecological problems	□ Measles/Rubella
□ Chronic cough	□ menstrual pain	□ encephalitis/ meningitis
□ pneumonia	□ pregnancy	□ herpes
□ heart disease	□ HIV/AIDS	□ Venereal disease
□ immune problems (lupus)	□ other	

_____

_____

DEVELOPMENTAL HISTORY:

Pregnancy/ Labor/ Delivery: □ Term □ Preterm Delivery
Complications at birth □ No □ Yes _____
Maternal postpartum depression: □ No □ Yes _____
Met developmental milestones on time □ No □Yes, if No describe any concerns _____

_____
Behavioral problems as a child: _____
Language and reading skills: □ As expected □ Had/Having problems
Special education services □ No □ Yes :_____
Repeated Grade: □ No □ Yes: _____

History of: □ Medical problems □School suspensions or expulsions □Sleep problems □ Police or legal problems □ Defiance / anger □Growth problems □ Running away □ School failure □Multiple school changes □ Friendship problems □ Family discord □ Divorce, illness / loss □Financial strains □ Physical or emotional trauma □ Sexual identity or preference concerns □ Self mutilation □ Bizarre behavior or ideas

History of abuse? □ No □ Yes
Has sex ever been forced? □ No □ Yes
Has there ever been a Protective Service case open □ No □ Yes
Legal problems? □ No □ Yes
Sexual/ Gender issues? _____

MENTAL HEALTH HISTORY:

Previous counseling, therapy, or psychiatric treatment? _____
Has anyone in the family had any psychological or psychiatric problems? □ No □ Yes _____
_____
Ever been admitted to a state or local psychiatric facility? □ No □ Yes _____

EDUCATION/WORK:

Highest grade completed:_____ History of learning problems? □ No □ Yes
Current employment:_____

STRENGTHS AND ABILITIES:

What do you think are your strengths and abilities:_____
Describe your families strengths and abilities: _____

Child or Parent/ Guardian Signature & Date: _____

Clinician Signature & Credentials & Date: _____

Clinician Name (print): _____

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

By signing below, I acknowledge that I have received Birmingham Maple Clinic's Notice of Privacy Practices ("Notice").

_____ Date:_____

Signature (Patient or Authorized Representative)

_____

Printed (Patient or Authorized Representative)

BIRMINGHAM MAPLE CLINIC

JOINT NOTICE OF PRIVACY PRACTICES
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION PLEASE REVIEW IT CAREFULLY

Effective Date: September 20, 2013

OUR PLEDGE REGARDING MEDICAL INFORMATION

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated or otherwise maintained by Birmingham Maple Clinic.

This Notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- Maintain the privacy of your medical information that identifies you;
- Give you this Notice of our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of the Notice that is currently in effect.

WHO WILL FOLLOW THIS NOTICE

This Notice will cover Birmingham Maple Clinic and those health care providers who, while not necessarily legally affiliated with us, may provide you with care or treatment at Birmingham Maple Clinic. Together, Birmingham Maple Clinic and these providers are part of the "Birmingham Maple Clinic Organized Health Care Arrangement" (referred to as an "OHCA"). This Notice describes privacy practices of those participating in the Birmingham Maple Clinic OHCA. This Notice covers:

- Any health care professional authorized to enter information into any medical record established and maintained by Birmingham Maple Clinic.
- All departments and units of Birmingham Maple Clinic.
- All employees, staff, volunteers and other Birmingham Maple Clinic personnel.
- The individual health care providers of Birmingham Maple Clinic.
- Bradley S. Klein, D.O., P.L.C.
- Jeffrey A. London, M.D., P.C.
- Brooke Weingarden, D.O., M.P.H., P.L.L.C.

In addition, Birmingham Maple Clinic and the Birmingham Maple Clinic OHCA may share your medical information with each other for treatment, payment or health care operations purposes described in this Notice.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

The following categories describe different ways that we use and disclose your health information. For each category we explain what we mean and give some examples. Our records contain information regarding your mental health or may contain information on substance abuse; those records may be subject to additional restrictions under state law, which we will comply with. Also, if you are a minor, certain specific information that relates to mental health, substance abuse, pregnancy or sexually transmitted diseases, may be protected by additional restrictions under state law, which we will comply with. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

- **About Victims of Abuse.** We may disclose your health information to notify the appropriate government authority if we believe an individual has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

- **As Required By Law.** We will disclose your health information when required to do so by federal, state or local law or regulation.

- **Communications Regarding Our Services or Products.** We may use and disclose your health information to make a communication to you to describe a health-related product or service of Birmingham Maple Clinic. In addition, we may use or disclose your health information to tell you about products or services related to your treatment, case management or care coordination, or alternative treatments, therapies, providers or settings of care for you. We may occasionally tell you about another company's products or services, but will use or disclose your health information for such communications only if they occur in person with you. We may also use and disclose your health information to give you a promotional gift from us that is a minimal value.

- **Treatment Alternatives, Appointment Reminders and Health-Related Benefits.** We may use and disclose your health information to tell you about or recommend possible treatment alternatives or health-related benefits or services that may be of interest to you. Additionally, we may use and disclose your health information to contact you by mail or phone to provide appointment reminders. If you do not wish us to contact you about treatment alternatives, health-related benefits or appointment reminders, you must notify us in writing, and state which of those activities you wish to be excluded from.

- **Individuals Involved in Your Care or Payment for Your Care.** We may release health information about you to a family member or relative, personal representative, or any other person identified by you who is involved in your health care. We may also give information to someone who is involved with or helps pay for your care. We may also tell your family, friends, personal representative or other person responsible for your health care your condition and that you are at a hospital.

- **Business Associates**. We sometimes contact with third-party business associates for services. For example, these business associates include billing services, medical transcriptionists, answering services, consultants, and attorneys. We will disclose your medical information to our business associates to the extent necessary for them to perform the requested services. Our business associates are required by law to protect your medical information just as we are required to do so.

OTHER USES OF HEALTH INFORMATION

Other uses and disclosures of health information not covered by this Notice or the laws that apply to us will be made only with your written authorization. These may include, but are not limited to, the following: (i) most uses and disclosures of psychotherapy notes; (ii) uses and disclosures for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of health information. If you provide us with authorization to use or disclose your health information, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose health information about you for the reasons covered by your written authorization.

You understand that we are unable to take back any disclosures we have already made under the authorization, and that we are required to retain our records of the care that we provided to you.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You have the following rights regarding health information we maintain about you:

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care. For example: You could ask that we not use or disclose information about your condition to a certain person to whom disclosure would otherwise be permitted. Also, we will honor a valid Court Order that you provide to us, which restricts disclosure of information about a child to a non-custodial parent.

- **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice.

  To obtain a paper copy of this Notice, contact us in writing and submit it to the individual at the address identified at the end of this Notice.

CHANGES TO THIS NOTICE

We reserve the right to change this Notice. We reserve the right to make the revised Notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice in a clear and prominent location to which you have access. The Notice is also available to you upon request. The Notice will contain on the first page, in the top right-hand corner, the effective date. In addition, if we revise the Notice, you may request a copy of the revised Notice then in effect.

COMPLAINTS

In the event that there is a breach of your unsecured health information – meaning an unauthorized disclosure where your health information has not been made unusable, unreadable, or indecipherable – we are required to notify you of such breach.

Upon receiving such notification, or if you believe your privacy rights have otherwise been violated, you may file a complaint with Birmingham Maple Clinic or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact the Privacy Officer at the address listed at the end of this Notice. All complaints must be submitted in writing.

You will not be penalized or retaliated against for filing a complaint.

If you have any questions about this Notice, please contact:

Privacy Officer - Birmingham Maple Clinic, Inc.
2075 West Big Beaver Road
Suite 520
Troy, Michigan 48084

Birmingham Maple Clinic

2075 W. Big Beaver
Troy, MI 48084
Phone (248) 646-6659
Facsimile (248) 642-8645
www.birminghammaple.com

As a convenience to our clients, we can accept payment automatically by charging your Visa, MasterCard, or Discover on a twice per month basis. If you are interested in making payments with your Visa, MasterCard, or Discover, please complete the information below. **We do not accept American Express.**

PREAUTHORIZATION FORM

I _____ authorize Birmingham Maple Clinic to
(Please Print)
charge my **balance due** with the following credit card.

Credit Card Number: _____

Expiration Date: _____

Security Code: _____

Patient Name _____

Billing Address _____
Street City Zip

Home #(____) _____-_____ Work #(____) _____-_____Cell # (____) _____-_____

_____ _____
Cardholder's Signature Date

OFFICE USE ONLY:

Client #: _____ Therapist: _____ Date Entered: _____