Patient Info

First Name: _____ Last Name: _____ Middle Initial: ____

Preferred Name: _____ D.O.B: _____SSN: _____-_____-_____

Mailing Address: _____ Apt/ Unit #: _____

City: _____ State: _____ Zip Code: _____

Cell Phone: (_____) _____-_____ Home Phone: (_____) _____-_____

Email Address: _____

Referred By? _____

Are you currently (please check one):

☐ Employed ☐ Student ☐ Unemployed ☐ Retired

Employer/School Name: _____

Occupation: _____ Work Phone: (____)_____-_____

Please mark the best method of communication for appointment reminders, payment reminders, and confidential messages.

☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ Email ☐ Standard Mail

Emergency Contact

Emergency Contact: _____ Relationship: _____

Cell Phone: (_____) _____-_____

Emergency Contact:_____ Relationship:_____

Cell Phone: (_____) _____-_____

Pharmacy Information:

Pharmacy Name: _____ Phone Number: (____) _____-_____

Address: _____ Fax Number: (___) _____-_____

TMS of Tampa
2909 West Bay to Bay Blvd., Suite 210
Tampa, FL 33629
Phone: (813) 434-1981
Fax: (813) 350-9544

Dr. George Northrup, MD
Paul Estrada, APRN
Megan Desrosiers, LMHC
https://www.tmsoftampa.com/

Northrup Psychiatry
3601 West Azeele St.
Tampa, FL 33609
Phone: (813) 350-9500
Fax: (813) 350-9544

Self- Pay: ☐Yes ☐No

Primary Insurance

Please include a copy of the front and back of your insurance card(s).

Company Name: _____

Member ID #: _____ Group Number: _____

Name of Policy Holder: _____ Policy Holder DOB: ___ /___/_____

Policy Holder's Relationship to the Patient: _____

Insurance Provider Phone Number: (_____) _____-_____

Secondary Insurance (if applicable)

Company Name: _____

Member ID #: _____ Group Number: _____

Name of Policy Holder: _____ Policy Holder DOB: ____ /____/____

Policy Holder's Relationship to the Patient: _____

Insurance Provider Phone Number: (_____) _____-_____

Other Provider Information:

If you would like your medical records from other providers to be a part of your patient chart at our office, please make copies as needed and fill out the attached "*Medical Records Request Form*" for each provider.

Primary Care Physician

Provider's Name: _____ Name of Practice: _____

Address: _____

Phone Number: (_____)_____-_____ Fax Number: (_____)_____-_____

Has your PCP prescribed psychiatric medications for you in the past? ☐ Yes ☐ No

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Previous Psychiatrist (or Current Psychiatrist if seeing us for TMS)

Provider's Name: _____ Name of Practice: _____

Address: _____

Phone Number: (_____) _____-_____ Fax Number: (_____) _____-_____

Psychologist/ Therapist/ Counselor (PhD, PsyD, LCSW, LMHC, etc.)

Provider's Name: _____ Name of Practice: _____

Address: _____

Phone Number: (_____) _____-_____ Fax Number: (_____) _____-_____

Provider's Name: _____ Name of Practice: _____

Address: _____

Phone Number: (_____) _____-_____ Fax Number: (_____) _____-_____

Pain Management Provider

Provider's Name: _____ Name of Practice: _____

Address: _____

Phone Number: (_____) _____-_____ Fax Number: (_____) _____-_____

Other Specialist

Provider's Name: _____ Name of Practice: _____

Address: _____

Phone Number: (_____) _____-_____ Fax Number: (_____)_____-_____

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PATIENT ACKNOWLEDGEMENT

Patient Consent to Treatment: **Initials: _____**

I hereby authorize George M Northrup M. D PA employees and agents to administer treatment. This in no way constitutes a warranty or guarantee that my present condition will be cured. George M Northrup M. D PA staff and employees will provide me with the best possible care available, but no assurance of cure is to be assumed. I sign this willingly and voluntarily in full understanding of the above, and in so doing I release George M Northrup M. D PA directors and officers, staff employees, agents and physicians from any and all liability which may arise from this action, whether or not foreseen at present. I understand that it is my responsibility to inform the doctor of my medical and psychiatric background. I understand that refusal to abide by prescribed treatment (e.g., not taking or overtaking prescribed medications, missing, or rescheduling appointments repeatedly) is basis for termination of care due to noncompliance. On this basis, I authorize to render the necessary psychiatric services, as deemed advisable and have been notified of any possible side effects of any medications I have been prescribed.

Release and Assignment of Benefits: **Initials: _____**

I authorize George M Northrup M. D PA staff to release any medical information necessary to process my insurance claim(s). I hereby assign all medical, including major medical benefits to which I am entitled, private insurance and any other insurance programs to George M Northrup M. D PA. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all my charges whether or not paid by said insurance. If said insurance company has not made payments within 60 days, I understand that I will be responsible for any outstanding charges. This assignment will not apply when the balance has been paid as noted on claim form. If patient defaults in payment, patient agrees to pay collection costs and responsible attorney fees associated with the collection of outstanding balance.

Treatment Consent: **Initials: _____**

I consent to psychiatric evaluation and treatment with George M Northrup M. D PA and/or his associates. I further consent that if I initiate email contact with Dr Northrup or his staff, then that shall serve as my consent for Dr Northrup and his staff to communicate back to me via email, including the transmission of any confidential information regarding my case, via email. With this consent, I agree to not hold Dr Northrup nor any of his staff liable if there is a security breach or leak of any of my confidential information sent via email in this aforementioned manner. I give my permission to release any medical or psychological information regarding my treatment to my insurance company via phone, fax, email, or correspondence. This authorization will not be used for any purpose other than stated. I may revoke this authorization in writing at any time. I have read and understand the above consent.

Paperwork and Forms: **Initials: _____**

Forms that need to be completed by our physicians will have a fee of **$50-$150** depending on the time and complexity of the form. This will have to be paid prior to the form being completed. Please allow 5-7 business days for required paperwork such as disability, return to work or letters to specific individuals to be completed. (FMLA, Disability, Social Security, School, Letters)

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Prescriptions and Refills: Initials: _____

- ✓ Prescriptions will be routed to your designated pharmacy after your appointment.
- ✓ Make sure you have enough medication to last until your next appointment.
- ✓ No refill requests will be processed after 12 noon on Fridays.
- ✓ Prescription refills before appointment **$30**

Prescription refills or requests must have a follow up appointment scheduled as well as a 3- day notice must be given for all prescription refill requests. Prescription refills will not be phoned in the same day as the request. There will be no exceptions. You will need to be responsible and keep track of your medications. If you have cancelled or missed an appointment there will be a **$30** charge for medication refills.

Narcotics: If you are prescribed a controlled substance and you misplaced the written prescription and/or the medication itself, you will not be given another prescription until you are due. It is the patient's responsibility to keep medication in a safe place. If you take more than prescribed and do not discuss this matter with the physician/provider, you will not be granted an early refill without an appointment. If it is found that your prescribed medication is being misused this could result in immediate termination of care.

The State of Florida follows all controlled substance medication in a secure website. George M Northrup M. D PA does random checks on patients to see which controlled substances are prescribed. If it is found that you are getting the same medication from another physician, this will be grounds for termination of care.

No Show and Cancellation Fees: Initials: _____

For follow up appointments, you will be charged **$85** for cancellations that occur with less than a 24-hour notice prior to your appointment to the card on file. You will automatically be charged **$85** for missed scheduled follow up appointment to the card on file the day you miss. This fee is not covered by insurance and cannot be submitted for insurance reimbursement.

In fairness to other patients and in order to provide safe treatment to engaged patients who are most likely to benefit, repeated no shows or late cancellation may be cause to discontinue treatment at our practice.

Credit Card on File:

We have implemented a policy which enables us to maintain your credit card information securely on file. In providing us with your credit card information, you are giving George M Northrup M. D PA permission to automatically charge your credit card on file for your co-pays, deductibles, and all other fees due for service. You understand this agreement will remain in effect until the expiration of the credit card account and that you may revoke this form at any time by submitting a written request.

Co-pays: Co-pays are due at time of the office visit

Outstanding Balance: If your insurance provider has paid their portion of your bill and there is an outstanding balance owed, George M Northrup M. D PA will notify you via mailed patient statement. **If by the final billing notice, we do not receive a response from you or your payment in full, at that time, any balance owed will be charged to you credit card.** A copy of the charge wil be sent by email or mailed to you. This in no way compromises your ability to dispute a charge or question your insurance company's determination of payment.

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Methods of Payment: **Initials: _____**

Payments can be made in the form of cash, money order, Visa, Mastercard, Discover or check. Please make checks payable to: George M Northrup M. D PA

Returned checks will result in a fee of **$50** along with the original amount due. This must be paid prior to any future appointments being scheduled or an approved payment arrangement. The payment arrangement will be decided on a patient-to-patient basis. The company has the right to refuse future checks from that patient.

FEES: Patients without insurance coverage must pay at the time of service. A new patient initial psychiatric evaluation is **$300-$450** and **$125-$150** for subsequent visits.

INSURANCE: It is the patients' ultimate responsibility to know their insurance coverage. If it is found that a patient's insurance does not cover psychiatric care, the patient will be responsible for payment in full. As a courtesy, we have estimated your insurance portion and will process your claim for you. You are required to pay your estimated patient portion on the day when services are performed. You are required to obtain the authorization for your initial visit and are responsible for verifying on each subsequent visit that each visit has been authorized. We will verify your insurance coverage, but you are responsible if your insurance pays for the claim differently than we are informed.

If there are any delays on the part of your insurance company in processing the claim, it is your responsibility to contact the insurance carrier. We will expect payment in full from you if the insurance does not pay within 60 days of the service date. Any balance remaining after your insurance pays will be due and payable upon receipt of bill. Authorizations are based on medical necessity and are not a guarantee of payment by your insurance company.

Medical Records: **Initials: _____**

Medical records will be released only after a completed HIPAA (Health Insurance Portability and Accountability Act) compliant medical record release.

Media Release: **Initials: _____**

You grant permission to George M Northrup M. D PA the rights of your image, in video and still, and of the likeness and sound of your voice as recorded on audio or video tape. You understand your image may be edited, copied, exhibited, published, or distributed and waive the right to inspect or approve the finished product wherein your likeness appears. Additionally, you waive the rights to royalties or other compensation arising or related to the use of my image or recording. I also understand that this material may be used in diverse educational settings within an unrestricted geographic area. By signing you acknowledge to have read and fully understand the release. You may revoke this form at any time by submitting a written request.

AUTOMATIC BILLING AND CREDIT CARD AUTHORIZATION FORM

George M Northrup M.D PA
3601 W Azeele St
Tampa, FL 33609

I authorize George M Northrup M. D PA to charge my bill directly to the credit card listed below:

Name on Card: _____

Billing Address for card: _____

City, State, Zip: _____

_____

Card Number

_____ _____

CVV (3 digit code on back of card) Exp Date

☐ Bill all charges to the above card. Since the payment amount may vary, I will receive written notification of the amount and date of the next charge prior to each scheduled transaction date.

☐ This authorization is valid until I provide you with written cancellation.

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Name: _____ Date: _____

D.O.B: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

How long? _____ # of Children? _____

What brings you in today?

Allergies: _____

Psychiatric History

Have you ever been hospitalized for any psychiatric reasons? ☐ YES ☐ NO

If yes, how many times? _____ Reason? _____

Date of hospitalization? _____ Hospital? _____

Have you ever been placed under a Baker Act? ☐ YES ☐ NO

If yes, why? _____ Dates of hospitalization? _____

Have you ever attempted to commit suicide? ☐ YES ☐ NO

If yes, how did you attempt to harm yourself? _____

How many times? _____ Dates of hospitalization? _____

Are you or have you ever been in Psychotherapy? ☐ YES ☐ NO

If yes, mark all that apply: ☐ Individual ☐ Marital ☐ Family ☐ Group

Provider: _____

Is there history for any of the following? (***Mark all that apply)***

Yourself?		**Blood Relative?**	**Yourself?**		**Blood Relative?**
☐	Depression	☐	☐	Eating D/O	☐
☐	Anxiety D/O	☐	☐	Mania	☐
☐	Bi-Polar	☐	☐	Substance Abuse	☐
☐	Schizophrenia	☐	☐	Legal Problems	☐
☐	Suicide Attempts	☐	☐	Psychosis	☐

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Social History

Residence: ☐ Apartment ☐ House ☐ Other: _____

Currently Living With: ☐ Alone ☐ With a family member ☐ With a spouse or significant other

Employment Status *(Please check all that apply)*:

☐ Employed ☐ Unemployed ☐ Disabled ☐ Retired

Employer: _____

If on disability, please explain why? _____

Highest Level of Education: _____

Military History: ☐ YES ☐ NO

If yes, please give details of years active

I was raised by _____. I have ___ siblings (__ Brothers ___ Sisters)

Describe your maternal figure in 3 words _____

Describe your paternal figure in 3 words _____

Describe your childhood in 3 words _____

Parents' Marriage:

☐ Intact ☐ Divorced (Your age at time of event _____) ☐ Peaceful ☐ Conflictual ☐ Distant

Check all that Apply:

☐ **Tobacco**	☐ **Past**	☐ **Current**	**Avg # of packs/day _____ for # of years _____**
☐ **Alcohol**	☐ **Past**	☐ **Current**	**Avg # of drinks/ week_____ for # of years_____**
☐ **Cocaine**	☐ **Past**	☐ **Current**	**Avg use/week _____ for # of years _____**
☐ **Marijuana**	☐ **Past**	☐ **Current**	**Avg use/week _____ for # of years _____**
☐ **Speed/Amph**	☐ **Past**	☐ **Current**	**Avg use/week _____ for # of years _____**
☐ **Hallucinogens**	☐ **Past**	☐ **Current**	**# of trips lifetime_____**
☐ **Other**	☐ **Past**	☐ **Current**	**Substance_____ Details of Use:**

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Please check all that apply:

- ☐ Depressed mood
- ☐ Hopeless and helpless
- ☐ Don't do pleasure or leisure activities like I used to
- ☐ Feelings of guilt
- ☐ Feelings of worthlessness
- ☐ Low self esteem
- ☐ Decreased energy
- ☐ Decreased concentration
- ☐ Appetite or weight changes
- ☐ Moving slower or speaking slowly
- ☐ Feeling fidgety or have feeling of inner restlessness
- ☐ Sex drive changes
- ☐ Fatigued/tired most days
- ☐ Feel irritable often for no reason
- ☐ Harder to make decisions than I used to
- ☐ Sleep problems
  - ☐ Hard to get to sleep, but I stay asleep
  - ☐ Hard to stay asleep, but I et to sleep okay
  - ☐ Hard to get to sleep and hard to stay asleep
- ☐ Ideas of suicide or death
- ☐ Anxious
- ☐ Panic Attacks
- ☐ Fear of social situations
- ☐ Obsessions
- ☐ Compulsions
- ☐ Mood Swings
- ☐ Anger outbursts
- ☐ Decreased need for sleep
- ☐ More talkative
- ☐ Racing thoughts
- ☐ At times, I become overly distractable where even small things pull me away from important things
- ☐ At times, I do risky things more than usual like spend money out of control or get involved in sex or other adventures that often turn out badly
- ☐ At times, I am more impulsive than usual and do things that are totally out of character for me
- ☐ At times, I start many projects or get into so many activities that I can't complete, and I jump from one to another rapidly
- ☐ At times, I am unusually irresponsible and take action that cause moderate to severe problems (legal, financial, relationship) for me and my family
- ☐ I have experienced a traumatic event
- ☐ I often have the same nightmare or bad dream
- ☐ Memories come into my mind when I don't want them
- ☐ Sometimes I feel numb all over when I have some memories
- ☐ I avoid certain people and places I go
- ☐ Sometimes I feel so much fear that I detach myself or feel disassociation from people or places
- ☐ I am hyper-vigilant/hyper aware even when no danger is present
- ☐ I have many body aches and pains
- ☐ I have neck, back and other chronic pain
- ☐ I have headaches/migraines often
- ☐ I have had a head injury in the past
- ☐ Do you feel threatened or scared?
- ☐ Are people out to get you?
- ☐ Can you read people's thoughts?
- ☐ Can other people read your mind or know your thoughts?
- ☐ Does the TV or radio talk to you?
- ☐ Hear voices others can't?
- ☐ See things others can't?
- ☐ I have intrusive thoughts that are not my own
- ☐ I have special abilities or powers others do not have
- ☐ Thoughts are put inside my head by others
- ☐ I sometimes have out of body experiences

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Do you have any odd or unusual habits? (explain)

Do you have any habits that bother other people? (explain)

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AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

MEDICAL RECORDS CAN BE FAXED TO: (813) 350-9544 or
ADDRESS TO SEND VIA MAIL TO: George M Northrup MD PA
3601 W Azeele St
Tampa, FL 33609

I HEREBY REQUEST A COPY OF THE FOLLOWING PATIENT'S MEDICAL RECORDS:

Full Name of Patient: _____Maiden Name/ Alias: _____

Birth of Date: _____ Social Security Number: _____-_____-_____

INFORMATION REQUESTED: ☐ **Medical Record** ☐ **Psychiatric Records**

******If only a portion of the Medical record or Psychiatric record is required please specify******

☐ Discharge Summary ☐ Emergency Room ☐ Laboratory Results ☐ History & Physical
☐ Progress Notes ☐ Entire Record ☐ Other (Specify)*_____

IDENTIFY DATE OF SERVICE OR DATE RANGES REQUESTED INCLUDING MONTH AND YEAR:

_____

IDENTIFY THE HOSPITAL WHERE THE PATIENT WAS TREATED (IF APPLICABLE):

☐ Tampa General Hospital ☐ Memorial Hospital ☐ St. Joseph's Hospital ☐ Other: _____

THE ABOVE RECORD IS TO BE RELEASED FROM THE FOLLOWING:

Name & Title: _____

Street Address: _____ City/State/Zip: _____

Phone Number: _____ Fax Number: _____

THIS RECORD IS REQUESTED FOR THE FOLLOWING REASON:

☐ Continued Medical Care ☐ Legal Purposes ☐ Insurance Purposes ☐ Personal Interest

☐ Other (Specify)* _____

The authorization must be signed and dated and may be revoked by notifying Hospital's Health Information Department in writing at any time except to the extent action has been taken prior to revocation. This consent will expire 60 days after the date below or sooner by my choice, in which case this consent will expire on this date or event _____.

I understand that the medical record released pursuant to this authorization could contain information concerning drug related conditions, alcoholism, psychological conditions, psychiatric conditions, and/or blood borne infectious disease, which are subject to federal and/or state restrictions on disclosure. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations. I hereby affirm that I have read and fully understand the above statements and consent to the disclosure of the medical record for the purpose and extent stated above.

Signature _____ **Date** _____
Patient, Parent, or Legally Authorized Representative

Relationship to the Patient _____ **Phone Number** _____

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