

**NEW PATIENT INSURANCE VERIFICATION AND AUTHORIZATION**

George M. Northrup, M.D.

Date:	_____	Referred By:	_____
Patient Name:	_____	Cell Phone:	_____
Home Phone:	_____	Email:	_____
Home Address:	_____		
(City,State,Zip)	_____		
Employer Name:	_____	Work Phone:	_____
Employer Address:	_____		
Date of Birth:	_____	Social Security #:	_____
Insurance Company:	_____		
Benefits Telephone:	_____		
<b>Name of Insured:</b>	_____	Insured Employer:	_____
Insured Date of Birth:	_____	Insured SS#:	_____
Relationship to Patient:	_____		
Member Identification #:	_____	Employer Group#:	_____
Authorization Required?	Yes	No	
Have you already obtained an authorization??	Yes	No	Auth# _____
<b>DO NOT COMPLETE BELOW THIS LINE. FOR OFFICE USE ONLY.</b>			

EDOC: \_\_\_\_\_ Deductible: \_\_\_\_\_ Met to Date: \_\_\_\_\_

% of Coverage: \_\_\_\_\_ Yearly Max: \_\_\_\_\_

Co-pay 1st visit: \_\_\_\_\_ Co-pay follow-ups: \_\_\_\_\_

Claims Mailing Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Authorization Number: (90801 x \_\_\_) \_\_\_\_\_ (90805-62 x \_\_\_) \_\_\_\_\_

Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**GEORGE M. NORTHRUP, M.D.**

GENERAL PSYCHIATRY – FORENSIC PSYCHIATRY

3601 WEST AZEELE STREET  
TAMPA, FLORIDA 33609

OFFICE (813) 350-9500  
FACSIMILE (813) 350-9544

**Notice of Privacy Practices  
Patient Acknowledgement**

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

I have received and understand this practice’s Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice’s legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and make changes regarding all protected health information resident at, or controlled by this practice. If changes to the policy occur, this practice will provide me a revised Notice of Privacy Practices upon request.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Relationship to patient (if signed by a personal representative of patient):

\_\_\_\_\_

# New Patient Questionnaire

Name \_\_\_\_\_ Date \_\_\_\_\_

DOB \_\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Sex \_\_\_\_\_

Sexual Orientation: (check)    Heterosexual    Homosexual / Lesbian    Bisexual    Transexual

Marital Status:    Married    Separated    Divorced    Widowed    Single    Domestic Partnership

Living Situation (eg..own/rent, who is in household) \_\_\_\_\_

Allergies \_\_\_\_\_

### General – (check all that are problems for you)

- |   |   |
|---|---|
| 1 ___ not getting along with other people                 | 6 ___ acting rude or overbearing              |
| 2 ___ not fitting in with peers                           | 7 ___ being suspicious of others              |
| 3 ___ being shy   | 8 ___ not having close friends                |
| 4 ___ being uncomfortable when talking to people          | 9 ___ feeling lonely                          |
| 5 ___ feeling uncomfortable in social settings            | 10 ___ feeling like people are against me     |
| 11 ___ feeling anxious or uptight                         | 16 ___ having been traumatized                |
| 12 ___ being afraid of things                             | 17 ___ having nightmares                      |
| 13 ___ not being able to stop worrying                    | 18 ___ having flashbacks                      |
| 14 ___ not being able to relax                            | 19 ___ avoiding people, places or things      |
| 15 ___ feeling restless/tense                             |   |
| 20 ___ being overweight                                   | 22 ___ having unattractive face               |
| 21 ___ having physical handicap                           | 23 ___ being noticed for physical appearance  |
| 24 ___ other problem with appearance: _____               |   |
| 25 ___ being afraid of failing on the job                 | 29 ___ job having no future                   |
| 26 ___ boss being critical or unfair                      | 30 ___ being bored on the job                 |
| 27 ___ working too many hours                             |   |
| 28 ___ job creating health problems                       |   |
| 31 ___ children misbehaving                               | 36 ___ partner being unfaithful               |
| 32 ___ disagreeing on how to raise children               | 37 ___ having sexual problems in relationship |
| 33 ___ child or partner having medical problem            | 38 ___ being unfaithful to partner            |
| 34 ___ child or partner having emotional problem          | 39 ___ spouse working too many hours          |
| 35 ___ partner having problem with drugs or alcohol       | 40 ___ arguing with partner over money        |
| 41 ___ other regarding spouse, children or in-laws: _____ |   |
| 42 ___ budgeting money                                    | 47 ___ wasting money                          |
| 43 ___ not making enough money                            | 48 ___ spouse being careless with money       |
| 44 ___ not having a steady income                         |   |
| 45 ___ having to spend savings                            | 49 ___ worry about diseases or illness        |
| 46 ___ having unpaid bills                                |   |

50 \_\_\_\_ having problems with sexual relationship

52 \_\_\_\_ being troubled by sexual attitudes of others

51 \_\_\_\_ disliking sex

53 \_\_\_\_ being troubled by unusual sexual behavior

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

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

Is there a history for any of the following in :

Yourself	A blood relative	
Depression	Depression	If Hospitalizations (Yourself) or legal problems explain: _____ _____
Anxiety	Anxiety	
Substance Abuse	Substance Abuse	
Psych. Hospitalization	Psych. Hospitalization	
Legal Problems	Legal Problems	
Suicide Attempt	Suicide attempt	

I was raised by \_\_\_\_\_ I have \_\_\_\_\_ siblings. ( \_\_\_ Brothers. \_\_\_ Sisters)

Describe your maternal (i.e. mother) figure in 3 words \_\_\_\_\_

Describe your paternal (i.e. father) figure in 3 words \_\_\_\_\_

Describe your childhood in 3 words \_\_\_\_\_

**MEDICAL**

Current Medication	Dosage	Reason for medication

Year	Where	Hospitalizations/Surgeries	Nature of Illness

**Medical Cont'd**

Is there a history of the following in :

Yourself	A Blood Relative
High blood pressure	High Blood Pressure
Diabetes	Diabetes
Stroke	Stroke
Heart Attack	Heart Attack
Cancer	Cancer
Type _____	Type _____
Thyroid Problem	Thyroid Problem
Liver Problem	Liver Problem
Kidney Problem	Kidney Problem
Alzheimers	Alzheimers

**Social**

Education: Highest Grade Completed 1-12 \_\_\_\_\_

Additional Education: \_\_\_\_\_

Military History: Y N : if Y please give details below

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

**Substance use habits**

Circle all that apply:

- Tobacco    Past    Current    Avg. # of packs/day \_\_\_\_\_ for # of years \_\_\_\_\_
- Alcohol    Past    Current    Avg. # of drinks/week \_\_\_\_\_ for # of years \_\_\_\_\_ # of DUI charges \_\_\_\_\_
- 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 \_\_\_\_\_

**Physical Symptom Inventory**

Have you ever had any of the following?

Yes

No

Significant Weight gain? (\_\_\_\_ lbs.)

Significant Weight loss? (\_\_\_\_ lbs.)

Weakness in arms or legs?

Headaches which are chronic or severe?

Difficulty walking?

Loss of consciousness?

Problems with vision other than needing glasses?

Change in hearing?

Dizziness?

	Yes	No
Daily Cough?		
Shortness of breath?		
Discomfort in chest?		
	Yes	No
Frequent swelling in ankles?		
Pain in legs while standing?		
High blood pressure?		

---

	Yes	No
Severe abdominal pain?		
Frequent heartburn or indigestion?		
Tar-colored or bloody bowel movements?		
Do you lose control of stool at times?		

---

	Yes	No
Bloody or unusual appearing urine?		
Do you lose control of urine at times?		
Frequent awakening at night?		
Any skin problems?		
Neck pain or stiffness?		
Back pain or injury?		
Sexual problems?		

**IS THERE ANYTHING YOU WOULD LIKE TO ADD WHICH YOU HAVE NOT ALREADY?**

---



---

**APPOINTMENT CONFIRMATION OR OTHER TELEPHONE CALLS FROM THIS OFFICE MAY BE MADE TO:**  
**NUMBER(s):** \_\_\_\_\_ . **OKAY TO LEAVE MESSAGE?**    **Y**    **N**

**IN CASE OF EMERGENCY YOU HAVE MY PERMISSION TO CONTACT:**  
**NAME & RELATIONSHIP TO PATIENT:** \_\_\_\_\_ **PHONE:** \_\_\_\_\_

**SIGNATURE OF PATIENT:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**IF YOU ARE HERE FOR A SOCIAL SECURITY, SHORT TERM DISABILITY, LONG TERM DISABILITY OR FMLA EVALUATION PLEASE COMPLETE THE FOLLOWING:**

REASON FOR LEAVE/SYMPTOMS?

---

---

---

REFERRING PRIMARY CARE PHYSICIAN NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

DATE OF ONSET OF SYMPTOMS: \_\_\_\_\_ DATE OF LAST DAY WORKED: \_\_\_\_\_

NURSE CASE MANAGER NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

HAS THIS REQUEST BEEN DENIED BY ANOTHER OTHER PHYSICIAN WITHIN THE PAST 30 DAYS?    Y    N

IF YOU ANSWERED, YES PLEASE STATE REASON FOR DENIAL: \_\_\_\_\_

**PATIENT ACKNOWLEDGEMENT OF FORMS POLICIES. PLEASE READ AND INITIAL BELOW.**

**I AM AWARE I WILL BE CHARGED A MINIMUM \$30 PREPAYMENT FOR COMPLETION OF MY INITIAL FORMS. I AM ALSO AWARE I WILL BE CHARGED AN ADMINISTRATION FEE OF \$5.00 PER PAGE FOR ANY ADDITIONAL FORMS REQUESTED BY THE INSURANCE COMPANY AND/OR EMPLOYER. I UNDERSTAND THAT FORMS WILL ONLY BE SUBMITTED UPON PAYMENT OF THESE FEES. COMPLETION OF FORMS DOES NOT GUARANTEE APPROVAL OF YOUR CLAIM/REQUEST. FINAL CONSIDERATIONS ARE MADE BY YOUR EMPLOYER/ CARRIER.**

I UNDERSTAND THE ABOVE INFORMATION PERTAINING TO FORM COMPLETION. **INITIAL:** \_\_\_\_\_

George M. Northrup, M.D., P.A.

**PATIENT ACKNOWLEDGEMENT**

\_\_\_\_\_ Remembering the date and time of my scheduled appointment is my responsibility. Reminder calls are a courtesy and do not negate my responsibility for my sessions. I agree to provide the office a minimum of 24 hours notice if I need to cancel/ reschedule my appointment.

This office does it best to stay on schedule. As such, we do not overbook appointments. Scheduling an appointment fills a slot on Dr. Northrup's schedule. Missing appointments or arriving late not only disrupts the flow of the schedule, but also is not fair to other scheduled patients or to those who may need to be seen on an urgent basis.

\_\_\_\_\_ I understand I will be billed \$85.00 for any appointment I fail to keep or cancel without 24 *business* hours notice.

\_\_\_\_\_ I may reduce my no show/cancellation fee to \$50 by leaving a working credit card which will be run on file. I give my permission to keep the following credit card information on file:

VISA/ MC \_\_\_\_\_, EXP. \_\_\_\_/\_\_\_\_, BILLING ZIP \_\_\_\_\_  
and I understand my card will be billed in the event of the aforementioned. I understand I will receive written notification from the office if my card is charged.

\_\_\_\_\_ My portion of payment for services is due at the time services are rendered.

\_\_\_\_\_ I understand if my account is turned over to a collection agency for non-payment, I will be responsible for the collection agency fee as well.

\_\_\_\_\_ This physician's office has a relationship with ME, not my insurance company. Some insurance companies will deny various payments. The office will bill my insurance promptly. Whatever my insurance company does not pay, after 60 days, I will be billed for that total outstanding balance. I understand I have the right to question my insurance company's denial of fees or policies regarding mental health benefits. I further understand the physician's officer personnel will do their best to assist me in understanding and utilizing my benefits.

\_\_\_\_\_ I authorize release of my information, including my diagnosis, to all my Insurance Companies. I authorize this doctor's office to act as my agent in helping me obtain payment from my Insurance Companies. I authorize payment direct to this doctor's office.

\_\_\_\_\_ Although in most cases my prescription request will be handled on the same day, I will give this office a minimum of 1 business day notice when requesting a medication refill or new prescription.

My signature below and initial above indicate that I have read and understand and I agree to comply with all the above.

\_\_\_\_\_  
Signature of Responsible Party

\_\_\_\_\_  
Date

# DEPRESSION ASSESSMENT SCALE

Please check the answer to each question below which best applies to you:

## For the past two weeks I have been...

1. feeling unhappy or sad.

DO NOT AGREE	SLIGHTLY AGREE	MODERATELY AGREE	STRONGLY AGREE
-----------------	-------------------	---------------------	-------------------
2. angry or irritable more often than my old self.

DO NOT AGREE	SLIGHTLY AGREE	MODERATELY AGREE	STRONGLY AGREE
-----------------	-------------------	---------------------	-------------------
3. having little interest in fun activities.

DO NOT AGREE	SLIGHTLY AGREE	MODERATELY AGREE	STRONGLY AGREE
-----------------	-------------------	---------------------	-------------------
4. not sleeping like I normally do (whether sleeping too much or too little).

DO NOT AGREE	SLIGHTLY AGREE	MODERATELY AGREE	STRONGLY AGREE
-----------------	-------------------	---------------------	-------------------
5. not eating like I normally do (whether eating too much or too little).

DO NOT AGREE	SLIGHTLY AGREE	MODERATELY AGREE	STRONGLY AGREE
-----------------	-------------------	---------------------	-------------------
6. wishing I were dead, or thinking of suicide.

DO NOT AGREE	SLIGHTLY AGREE	MODERATELY AGREE	STRONGLY AGREE
-----------------	-------------------	---------------------	-------------------
7. unable to concentrate or pay attention very well.

DO NOT AGREE	SLIGHTLY AGREE	MODERATELY AGREE	STRONGLY AGREE
-----------------	-------------------	---------------------	-------------------
8. more forgetful than my old self.

DO NOT AGREE	SLIGHTLY AGREE	MODERATELY AGREE	STRONGLY AGREE
-----------------	-------------------	---------------------	-------------------
9. lacking motivation and energy.

DO NOT AGREE	SLIGHTLY AGREE	MODERATELY AGREE	STRONGLY AGREE
-----------------	-------------------	---------------------	-------------------
10. feeling down on myself and/or my future.

DO NOT AGREE	SLIGHTLY AGREE	MODERATELY AGREE	STRONGLY AGREE
-----------------	-------------------	---------------------	-------------------

# 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.**

We care about our patients' privacy and strive to protect the confidentiality of your medical information at this practice. New federal legislation requires that we issue this office Notice of our privacy practices. You have the right to the confidentiality of your medical information, and this practice is required by law to maintain the privacy of that protected health information. This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have any questions about this Notice, please contact the Privacy Officer at this practice.

**Privacy Officer:** Denise Wilson, Office Manager

**Effective:** April 7, 2003

## **Who Will Follow This Notice**

Any health care professional authorized to enter information into your medical record, all employees, staff and other personnel at the practice who may need access to your information must abide by this Notice. All subsidiaries, business associates, sites and locations of this practice may share medical information with each other for treatment purposes or health care operations described in this Notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be shared.

## **How We May Use and Disclose Medical Information About You**

The following categories describe different ways that we may use and disclose medical information without your specific consent or authorization. Examples are provided for each category of uses or disclosures. Not every possible use or disclosure in a category is listed.

**For Treatment.** We may use medical information about you to provide you with medical treatment services. Example: In treating you for a specific condition, we may need to know if you have allergies that could influence which medication we prescribe for the treatment process.

**For Payment.** We may use and disclose medical information about you so that the treatment and services you receive from us may be billed and payment may be collected from you, an insurance company or a third party. Example: We may need to send your protected health information, such as your name, address, office visit date, and codes identifying your diagnosis and treatment to your insurance company for payment.

**For Health Care Operations.** We may use and disclose medical information about you for health care operations to assure that you receive quality care. Example: We may use medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

## **Other Uses or Disclosure That Can Be Made Without Your Consent or Authorization**

- As required during an investigation by law enforcement agencies
- To avert a serious threat to public health or safety
- As required by military command authorities for their medical records
- To workers' compensation or similar programs for processing of claims
- In response to a legal proceeding
- To a coroner or medical examiner for identification of a body
- If an inmate, to the correctional institution or law enforcement official
- As required by the US Food and Drug Administration (FDA)

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

## **Uses and Disclosures of Protected Health Information Requiring Written Authorization**

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you give us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will thereafter no longer use or disclose medical 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 with your permission, and that we are required to retain records of the care we have provided you.

## **Your Individual Rights Regarding Your Medical Information**

**Complaints.** If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer at this practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized or discriminated against for filing a complaint.

**Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations or to someone who is involved in your care or the payment for your care. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. To request restrictions, you must submit your request in writing to the Privacy Officer at this practice. In your request, you must tell us what information you want to limit and where in your records this information is contained.

**Right to Request Confidential Communications.** You have the right to request how we should send communications to you about medical matters, and where you would like those communications sent. To request confidential communications, you must make your request in writing to the Privacy Officer at this practice. We will not ask you the reason for your request. We will accommodate all reasonable requests, but reserve the right to charge you a cost-based fee for any non-customary expenses involved. Your request must specify how or where you wish to be contacted.

**Right to Inspect and Copy.** You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records but does not include psychotherapy notes, information compiled for use in a civil, criminal or administrative action or proceeding, and protected health information to which access is prohibited by law. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer at this practice. If you request a copy of the information, we reserve the right to charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by this practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

**Right to Amend.** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at this practice. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request. If the information was not created by us, is not part of the medical information kept at this practice, is not part of the information which you would be permitted to inspect and copy, or which we deem to be accurate and complete. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Statements of disagreement and any corresponding rebuttals will be kept on file and sent out with any future authorized request for information pertaining to the appropriate portion of your record.

**Right to an Accounting of Non-Standard Disclosures.** You have the right to request a list of the disclosure we made of medical information about you. To request this list, you must submit your request in writing to the Privacy Officer at this practice. Your request must state the time period for which you want to receive a list of disclosures that is no longer than six years, and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (example: on paper or electronically). The first list you request in writing within a 12-month period will be free. For additional lists, we reserve the right to charge you for the cost of providing the list.

**Right to a Paper Copy of This Notice.** You have the right to a paper copy of this Notice of Privacy Practices at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy. To obtain a paper copy of the current Notice, please request one in writing from the Privacy Officer at this practice.

**Change to This Notice:** We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post the current Notice, with the effective date in the upper right corner.

